Filing at a Glance

Company:	Life Insurance Company of Alabama
Product Name:	Critical Illness
State:	Arkansas
TOI:	H07I Individual Health - Specified Disease - Limited Benefit
Sub-TOI:	H07I.001 Critical Illness
Filing Type:	Form/Rate
Date Submitted:	09/17/2012
SERFF Tr Num:	HESS-128670082
SERFF Status:	Closed-Approved
State Tr Num:	
State Status:	Waiting Industry Response
Co Tr Num:	AMHLOACIAR
Implementation Date Requested:	On Approval
Author(s):	Antoinette Hess
Reviewer(s):	Donna Lambert (primary)
Disposition Date:	12/17/2012
Disposition Status:	Approved
Implementation Date:	

State Filing Description:

General Information

Project Name: Individual Specified Disease
Project Number: AMHLOACIAR
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Filing Status Changed: 12/17/2012
State Status Changed: 11/29/2012
Created By: Antoinette Hess
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type:
Overall Rate Impact:

Deemer Date:
Submitted By: Antoinette Hess

Filing Description:

Critical Illness Benefit Policy - Form Number HH892012
Cancer Benefit Policy – Form Number HC882012
Critical Illness Outline of Coverage – Form Number OCHH892012
Cancer Outline of Coverage – Form Number OCHC882012
Health Screening Benefit Rider – Form Number HH89W2012
Health Screening Benefit Rider – Form Number HC89W2012
Application - Form Number MP AH 2012
Application – Form Number MP LIFE 2012

Hess Compliance Consulting is submitting the above-captioned forms, the actuarial memorandum and rates for the Department's review and approval on behalf of Life Insurance Company of Alabama. A letter of authorization is included with the filing.

These are new forms and are not intended to replace any previously approved forms.

Included with the filing are any required filing forms and filing fees.

Policy Form Number HH892012 is an Individual Critical Illness Benefit Policy. The policy provides for a lump sum benefit amount if a critical illness is diagnosed as defined in the policy. Payment of benefit maximum amount terminates the policy. The benefit maximum amount is reduced by the amount of all benefits paid. The total of all benefit payments cannot exceed the benefit maximum amount. No critical illness benefit is payable more than once. All of the benefit amounts and the benefit maximum amount, less any benefits previously paid, will be reduced by 50% when the insured attains the age of 70.

Critical Illnesses include a Heart Attack, Kidney Failure, Stroke, Major Organ Transplant, Coronary Artery Angioplasty and Coronary Artery By-Pass Grafting.

Health Screening Rider Form HH89W2012 will be offered to individuals purchasing the base form. The health screening tests are listed in the rider and are sold in units.

Policy Form HC882012 is an Individual Cancer Benefit Policy. The policy provides for a lump sum benefit amount if a covered cancer is diagnosed as defined in the policy. Payment of benefit maximum amount terminates the policy. The benefit maximum amount is reduced by the amount of all benefits paid. The total of all benefit payments cannot exceed the benefit maximum amount. No cancer benefit is payable more than once. All of the benefit amounts and the benefit maximum amount, less any benefits previously paid, will be reduced by 50% when the insured attains the age of 70.

Cancer includes Invasive and Non-Invasive Cancer.

Health Screening Rider Form HC88W2012 will be offered to individuals purchasing the base form. The health screening tests are listed in the rider and are sold in units.

The outlines of coverage for both policy forms are being submitted.

The applications being submitted reflect other coverages offered by the Company.

The policy will be marketed to individuals by contracted agents and brokers.

The forms are in final print, subject to minor variations in formatting, duplexing, shading and fonts. In addition, the Application may be reproduced electronically which could result in formatting changes. While every effort is made to submit filings without mistakes, the Company reserves the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval.

Hess Compliance Consulting appreciates the Department's time and review of this filing for Life Insurance Company of Alabama. Should you have any concerns or comments, please do not hesitate to contact me.

Sincerely,
Antoinette M. Hess, ACP
Compliance Consultant
toni.hess@hesscc.com
352-226-4860 (Cell Phone)
215-987-5888 (Land Line)

Company and Contact

Filing Contact Information

Toni Hess, Compliance Consultant
166 Thunder Circle
Bensalem, PA 19020

Toni.Hess@HessCC.Com
352-226-4860 [Phone]

Filing Company Information

(This filing was made by a third party - hesscomplianceconsulting)

Life Insurance Company of Alabama
302 Broad Street
Gadsden, AL 35901
(256) 543-2022 ext. [Phone]

CoCode: 65412
Group Code:
Group Name:
FEIN Number: 63-0321291

State of Domicile: Alabama
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$450.00
Retaliatory?	Yes

SERFF Tracking #: *HESS-128670082* ***State Tracking #:*** ***Company Tracking #:*** *AMHLOACIAR*

State: *Arkansas* ***Filing Company:*** *Life Insurance Company of Alabama*
TOI/Sub-TOI: *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*
Product Name: *Critical Illness*
Project Name/Number: *Individual Specified Disease/AMHLOACIAR*

Fee Explanation: $50 per form and $50 per rate
8 Forms @ $50 = $400.00
1 Rate @ $50 = $50.00

Per Company: No

Company	Amount	Date Processed	Transaction #
Life Insurance Company of Alabama	$450.00	09/17/2012	62753532

SERFF Tracking #:	HESS-128670082	**State Tracking #:**		**Company Tracking #:**	AMHLOACIAR

State:	Arkansas	**Filing Company:**	Life Insurance Company of Alabama
TOI/Sub-TOI:	H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness		
Product Name:	Critical Illness		
Project Name/Number:	Individual Specified Disease/AMHLOACIAR		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	12/17/2012	12/17/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	11/29/2012	11/29/2012
Pending Industry Response	Donna Lambert	11/29/2012	11/29/2012
Pending Industry Response	Donna Lambert	10/23/2012	10/23/2012
Pending Industry Response	Donna Lambert	09/20/2012	09/20/2012
Pending Industry Response	Donna Lambert	09/20/2012	09/20/2012

Response Letters

Responded By	Created On	Date Submitted
Antoinette Hess	12/13/2012	12/13/2012
Antoinette Hess	12/13/2012	12/13/2012
Antoinette Hess	11/26/2012	11/26/2012
Antoinette Hess	10/22/2012	10/22/2012
Antoinette Hess	10/22/2012	10/22/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request for Extension Granted	Note To Filer	Donna Lambert	10/23/2012	10/23/2012
Thank you for your note	Note To Filer	Donna Lambert	10/10/2012	10/10/2012
Question on Objection	Note To Reviewer	Antoinette Hess	10/08/2012	10/08/2012

SERFF Tracking #:	*HESS-128670082*	***State Tracking #:***		***Company Tracking #:***	*AMHLOACIAR*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Disposition

Disposition Date: 12/17/2012
Implementation Date:
Status: Approved

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Life Insurance Company of Alabama	0.000%	0.000%	$0	0	$0	0.000%	0.000%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document (revised)	Application	Approved	Yes
Supporting Document	Application	Replaced	Yes
Supporting Document	Application	Replaced	Yes
Supporting Document	Health - Actuarial Justification	Approved	Yes
Supporting Document (revised)	Outline of Coverage	Approved	Yes
Supporting Document	Outline of Coverage	Replaced	Yes
Supporting Document	Outline of Coverage	Replaced	Yes
Supporting Document	Outline of Coverage	Replaced	Yes
Supporting Document	Authorization Letter	Approved	Yes
Form (revised)	Critical Illness Benefit Policy	Approved	Yes
Form	Critical Illness Benefit Policy	Replaced	Yes
Form	Critical Illness Benefit Policy	Replaced	Yes

SERFF Tracking #:	*HESS-128670082*	***State Tracking #:***		***Company Tracking #:***	*AMHLOACIAR*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Critical Illness Benefit Policy	Replaced	Yes
Form	Critical Illness Benefit Policy	Replaced	Yes
Form (revised)	Cancer Benefit Policy	Approved	Yes
Form	Cancer Benefit Policy	Replaced	Yes
Form	Health Screening Rider	Approved	Yes
Form	Health Screening Rider	Approved	Yes
Rate	Rate Pages	Approved	Yes

State: Arkansas **Filing Company:** Life Insurance Company of Alabama
TOI/Sub-TOI: H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness
Product Name: Critical Illness
Project Name/Number: Individual Specified Disease/AMHLOACIAR

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/29/2012
Submitted Date	11/29/2012
Respond By Date	12/31/2012

Dear Toni Hess,

Introduction:

Please disregard the objection letter I just sent. I did not attach the objections!

Objection 1

- Critical Illness Benefit Policy, HH892012AR (Form)

Comments: Regarding item 3 and 15 in the previous objection letter, I understand your position, but if you will remove "within 31 days" the provision will be fine. The Bulletin just doesn't allow a time limit to be placed on the time of notification, and the Department requires this of all companies. Thank you for understanding. (And the proof will be paid at the insurer's expense.)

Objection 2

- Critical Illness Benefit Policy, HH892012AR (Form)

Comments: The revision to the last sentence in the Contestable Period provision (Item 20 of the previous objection letter) has not been made. Have I misread something?

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

State: Arkansas **Filing Company:** Life Insurance Company of Alabama
TOI/Sub-TOI: H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness
Product Name: Critical Illness
Project Name/Number: Individual Specified Disease/AMHLOACIAR

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/29/2012
Submitted Date	11/29/2012
Respond By Date	12/31/2012

Dear Toni Hess,

Introduction:

Thank you for your response to the previous objection letter. There are only a couple of items that still need to be revised. When those revisions are made, I will be happy to approve this submission right away.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

State: Arkansas **Filing Company:** Life Insurance Company of Alabama
TOI/Sub-TOI: H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness
Product Name: Critical Illness
Project Name/Number: Individual Specified Disease/AMHLOACIAR

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/23/2012
Submitted Date	10/23/2012
Respond By Date	11/23/2012

Dear Toni Hess,

Introduction:

I'm creating this objection so the SERFF status will change to PENDING INDUSTRY RESPONSE. I look forward to approving your forms after the revisions. (Notice the response isn't due until 11/23/12)

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

State: Arkansas **Filing Company:** Life Insurance Company of Alabama
TOI/Sub-TOI: H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness
Product Name: Critical Illness
Project Name/Number: Individual Specified Disease/AMHLOACIAR

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/20/2012
Submitted Date	09/20/2012
Respond By Date	10/22/2012

Dear Toni Hess,

Introduction:

Objection 1

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Please add the statement required by RR 17 Sec. 8(12) to the first page of the policy.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

State: Arkansas **Filing Company:** Life Insurance Company of Alabama
TOI/Sub-TOI: H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness
Product Name: Critical Illness
Project Name/Number: Individual Specified Disease/AMHLOACIAR

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/20/2012
Submitted Date	09/20/2012
Respond By Date	10/22/2012

Dear Toni Hess,

Introduction:

This will acknowledge receipt of the captioned filing.

Please request to withdraw the Cancer policy attached to this filing. It should be filed separately using the Sub-TOI "cancer." A filing fee will be required.

When refiling the Cancer policy, please address it to my attention for expedited review. Thank you.

Objection 1

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Notice of Right to Examine Policy

Please remove the word must from this paragraph. The word must implies a negative consequence if the company is not notified within 30 days.

Objection 2

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 4, Critical Illness definition - RR 17 Appendix 1A(3) states . . . Specified disease policies shall provide benefits to any covered person not only for the specified disease but also for any other conditions or diseases, directly caused or aggravated by the specified disease or the treatment of the specified disease. Please add this information to the Critical Illness definition.

Objection 3

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 4, Dependent Child or Dependent Children - Please remove the sentence requiring proof of incapacity to be received within [XX] days. Bulletin 14-81 1.A does not allow the company to place a time limit on the receipt of notice of the child's incapacity.

The insurer may request proof of incapacity, without placing a time limit on its receipt, if the proof is obtained at the insurers expense. 23-85-131(b)(2). Please add to the provision a statement that proof will be obtained at the company's expense.

Objection 4

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: On page 5, the definition of Diagnosed or Diagnosis does not appear to comply with RR 18 Appendix 1.A(9). Benefits must begin the first day of care or confinement even though the diagnosis is made at some later date, provided the diagnosis is made before 90 days after the first day of care or confinement. This would include a diagnosis made after death. Please revise item 3.

Objection 5

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: On page 5, the 3rd item in the definition of Incur or Incurred does not appear to comply with RR 18 Appendix 1.A(9). Benefits must begin the first day of care or confinement even though the diagnosis is made at some later date, provided the diagnosis is made before 90 days after the first day of care or confinement. This would include a diagnosis made after death. Please

revise this item.

Objection 6

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: On page 5, please add to the definition of Legal Spouse that spouse coverage terminates upon divorce subject to the Right of Conversion provision.

Objection 7

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: On page 6 in the first paragraph of the Critical Illness Benefits section, the last sentence of the first paragraph states: No Critical Illness Benefit is payable more than once. Does this mean once per individual on a family policy or just once per policy. Please consider adding a statement that clarifies whether or not the benefits will be paid once per individual on a family policy or once per policy. This will make the provision clearer to the insured.

Objection 8

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 6, Benefit Payment Conditions. Item (d) does not appear to comply with RR 18 Appendix 1.A(9). Benefits must begin the first day of care or confinement even though the diagnosis is made at some later date, provided the diagnosis is made before 90 days after the first day of care or confinement. This would include a diagnosis made after death. Please revise this item.

Objection 9

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 6, Heart Attack. Item 4 does not appear to comply with RR 18 Appendix 1.A(9). Benefits must begin the first day of care or confinement even though the diagnosis is made at some later date, provided the diagnosis is made before 90 days after the first day of care or confinement. This would include a diagnosis made after death. Please revise this item.

Objection 10

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 7, Kidney Failure - Please remove from the provision the restriction that the diagnosis must be made during the lifetime of the insured and not post mortem. Benefits must begin the first day of care or confinement even though the diagnosis is made at some later date, provided the diagnosis is made before 90 days after the first day of care or confinement. This would include a diagnosis made after death. Please revise this item. RR 18 Appendix 1.A(9).

Objection 11

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 7, Stroke - Please remove from item 4 the restriction that the diagnosis must be made during the lifetime of the insured and not post mortem. This appears to conflict with RR 18 Appendix 1.A(9). Benefits must begin the first day of care or confinement even though the diagnosis is made at some later date, provided the diagnosis is made before 90 days after the first day of care or confinement. This would include a diagnosis made after death. Please revise this item.

Objection 12

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 8, Right to Examine for all Critical Illnesses Please add a statement that the examination will be covered at the companys expense.

Objection 13

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 9, Exclusions - Please delete or revise the following exclusion: Any diagnosis made after the death of the Insured.

Objection 14

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 9, Termination of Insurance Please add to the third paragraph a statement that the termination of the spouses coverage is subject to the Right of Conversion provision.

Objection 15

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 10 - Please revise or remove the last paragraph of the Termination of Insurance section. Bulletin 14-81 1.A does not allow the company to place a time limit on the receipt of notice of the child's incapacity.

The insurer may request proof of incapacity, without placing a time limit on its receipt, if the proof is obtained at the insurers expense. 23-85-131(b)(2). Please add this information.

Objection 16

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 11, General Provisions, Payment of Premiums The last sentence of the first paragraph states that refund payments MAY be made to the insured after the companys receipt of the insureds written notice to discontinue coverage. Who would receive the refund if not the insured?

Objection 17

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 12 - Regarding the Notice of Claim provision, ACA 23-85-110 does not allow a time limit for providing notice of claim other than as soon thereafter [60 days] as is reasonably possible. Please remove the 180 day restriction.

Objection 18

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 12 - Regarding the Payment of Claims provision, the amount payable cannot be less than $1,000. Since the amount stated ($3,000) is not variable, please clarify in the contract that the company will not pay less than $1,000.

Objection 19

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 13, Contestable Period - Please remove:
If We do not receive sufficient documentation from You to properly investigate Your claim that is within this 2 year contestable period, We retain the right to void the Policy and refund all premiums We have received. We will provide You with Written Notice fifteen (15) days before the Policy is voided.

23-85-107, Time Limit on Certain Defenses, does not allow the company to void the policy for this reason.

(In addition, the Contestable Period provision, as it now stands, conflicts with the Date of Diagnosis definition in that the definition states the date of diagnosis means the date [the illness] was first diagnosed,[not] the date the diagnosis [was] communicated to [the insured.] It is possible for the insured to be diagnosed with a Critical Illness but not receive notice of the diagnosis until after the two-year contestability period.)

Objection 20

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 13 - The last sentence of the Contestable Period provision states Misstatements, INCLUDING Fraudulent Misstatements . . . .
ONLY Fraudulent misstatements can be used to contest. Please revise this sentence.

Objection 21

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 13, Contestable Period - Please add that all statements are representations and not warranties.

Objection 22

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 9-10, Termination of Insurance - Please add a statement that the termination of the Dependent Childs coverage is subject to the Right of Conversion provision.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

SERFF Tracking #:	HESS-128670082	**State Tracking #:**		**Company Tracking #:**	AMHLOACIAR

State:	Arkansas	**Filing Company:**	Life Insurance Company of Alabama
TOI/Sub-TOI:	H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness		
Product Name:	Critical Illness		
Project Name/Number:	Individual Specified Disease/AMHLOACIAR		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	12/13/2012
Submitted Date	12/13/2012

Dear Donna Lambert,

Introduction:

This is in response to the objection of 11/29/12.

Response 1

Comments:

Reference to the 31 days has been deleted.

Related Objection 1

Applies To:

- Critical Illness Benefit Policy, HH892012AR (Form)

Comments: Regarding item 3 and 15 in the previous objection letter, I understand your position, but if you will remove "within 31 days" the provision will be fine. The Bulletin just doesn't allow a time limit to be placed on the time of notification, and the Department requires this of all companies. Thank you for understanding. (And the proof will be paid at the insurer's expense.)

Changed Items:

No Supporting Documents changed.

SERFF Tracking #: *HESS-128670082* **State Tracking #:** **Company Tracking #:** *AMHLOACIAR*

State: *Arkansas* **Filing Company:** *Life Insurance Company of Alabama*
TOI/Sub-TOI: *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*
Product Name: *Critical Illness*
Project Name/Number: *Individual Specified Disease/AMHLOACIAR*

Form Schedule Item Changes:

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Critical Illness Benefit Policy	HH892012AR	POL	Initial		46.100	HH892012AR.pdf	Date Submitted: 12/13/2012 By: Antoinette Hess
Previous Version								
1	*Critical Illness Benefit Policy*	*HH892012AR*	*POL*	*Initial*		*46.100*	*HH892012AR.pdf*	*Date Submitted: 12/13/2012 By: Antoinette Hess*
Previous Version								
1	*Critical Illness Benefit Policy*	*HH892012AR*	*POL*	*Initial*		*46.100*	*HH892012AR.pdf*	*Date Submitted: 11/26/2012 By: Antoinette Hess*
Previous Version								
1	*Critical Illness Benefit Policy*	*HH892012*	*POL*	*Initial*		*46.100*	*HH892012OK.pdf*	*Date Submitted: 10/22/2012 By: Antoinette Hess*
Previous Version								
1	*Critical Illness Benefit Policy*	*HH892012*	*POL*	*Initial*		*46.100*	*LOA HH892012 Critical Illness Policy - Final.pdf*	*Date Submitted: 09/17/2012 By: Antoinette Hess*

No Rate/Rule Schedule items changed.

SERFF Tracking #:	HESS-128670082	**State Tracking #:**		**Company Tracking #:**	AMHLOACIAR

State:	Arkansas	**Filing Company:**	Life Insurance Company of Alabama
TOI/Sub-TOI:	H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness		
Product Name:	Critical Illness		
Project Name/Number:	Individual Specified Disease/AMHLOACIAR		

Response 2

Comments:

The sentence has been removed.

Related Objection 2

Applies To:

- Critical Illness Benefit Policy, HH892012AR (Form)

Comments: The revision to the last sentence in the Contestable Period provision (Item 20 of the previous objection letter) has not been made. Have I misread something?

Changed Items:

SERFF Tracking #:	*HESS-128670082*	***State Tracking #:***		***Company Tracking #:***	*AMHLOACIAR*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Supporting Document Schedule Item Changes

Satisfied - Item:	Application
Comments:	
Attachment(s):	
MP A&H 2012.pdf MP LIFE 2012.pdf	
Previous Version	
Satisfied - Item:	*Application*
Comments:	
Attachment(s):	
MP A&H 2012.pdf *MP LIFE 2012.pdf*	
Previous Version	
Satisfied - Item:	*Application*
Comments:	
Attachment(s):	
LOA MP AH 2012 ONLY.pdf *LOA MP LIFE 2012 ONLY.pdf*	
Satisfied - Item:	Outline of Coverage
Comments:	
Attachment(s):	
OCHH892012 AR.pdf	
Previous Version	
Satisfied - Item:	*Outline of Coverage*
Comments:	*The Company is formally withdrawing the Outline of Coverage for the Cancer Policy.*
Attachment(s):	
OCHH892012 AR.pdf	

SERFF Tracking #:	HESS-128670082	**State Tracking #:**		**Company Tracking #:**	AMHLOACIAR

State:	Arkansas	**Filing Company:**	Life Insurance Company of Alabama
TOI/Sub-TOI:	H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness		
Product Name:	Critical Illness		
Project Name/Number:	Individual Specified Disease/AMHLOACIAR		

Supporting Document Schedule Item Changes

Previous Version	
Satisfied - Item:	*Outline of Coverage*
Comments:	*The Company is formally withdrawing the Outline of Coverage for the Cancer Policy.*
Attachment(s):	
LOA OCHH892012 Outline Critical Illness.pdf	
Previous Version	
Satisfied - Item:	*Outline of Coverage*
Comments:	
Attachment(s):	
LOA OCHH892012 Outline Critical Illness.pdf *OCHC882012 Outline CI Cancer.pdf*	

SERFF Tracking #:	*HESS-128670082*	***State Tracking #:***		***Company Tracking #:***	*AMHLOACIAR*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Supporting Document Schedule Item Changes

Satisfied - Item:	Application
Comments:	
Attachment(s):	
MP A&H 2012.pdf MP LIFE 2012.pdf	
Previous Version	
Satisfied - Item:	*Application*
Comments:	
Attachment(s):	
MP A&H 2012.pdf *MP LIFE 2012.pdf*	
Previous Version	
Satisfied - Item:	*Application*
Comments:	
Attachment(s):	
LOA MP AH 2012 ONLY.pdf *LOA MP LIFE 2012 ONLY.pdf*	
Satisfied - Item:	Outline of Coverage
Comments:	
Attachment(s):	
OCHH892012 AR.pdf	
Previous Version	
Satisfied - Item:	*Outline of Coverage*
Comments:	*The Company is formally withdrawing the Outline of Coverage for the Cancer Policy.*
Attachment(s):	
OCHH892012 AR.pdf	

SERFF Tracking #:	HESS-128670082	**State Tracking #:**		**Company Tracking #:**	AMHLOACIAR

State:	Arkansas	**Filing Company:**	Life Insurance Company of Alabama
TOI/Sub-TOI:	H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness		
Product Name:	Critical Illness		
Project Name/Number:	Individual Specified Disease/AMHLOACIAR		

Supporting Document Schedule Item Changes

Previous Version	
Satisfied - Item:	*Outline of Coverage*
Comments:	*The Company is formally withdrawing the Outline of Coverage for the Cancer Policy.*
Attachment(s):	
LOA OCHH892012 Outline Critical Illness.pdf	
Previous Version	
Satisfied - Item:	*Outline of Coverage*
Comments:	
Attachment(s):	
LOA OCHH892012 Outline Critical Illness.pdf *OCHC882012 Outline CI Cancer.pdf*	

SERFF Tracking #: *HESS-128670082* **State Tracking #:** **Company Tracking #:** *AMHLOACIAR*

State: *Arkansas* **Filing Company:** *Life Insurance Company of Alabama*
TOI/Sub-TOI: *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*
Product Name: *Critical Illness*
Project Name/Number: *Individual Specified Disease/AMHLOACIAR*

Form Schedule Item Changes:

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Critical Illness Benefit Policy	HH892012AR	POL	Initial		46.100	HH892012AR.pdf	Date Submitted: 12/13/2012 By: Antoinette Hess
Previous Version								
1	*Critical Illness Benefit Policy*	*HH892012AR*	*POL*	*Initial*		*46.100*	*HH892012AR.pdf*	*Date Submitted: 12/13/2012 By: Antoinette Hess*
Previous Version								
1	*Critical Illness Benefit Policy*	*HH892012AR*	*POL*	*Initial*		*46.100*	*HH892012AR.pdf*	*Date Submitted: 11/26/2012 By: Antoinette Hess*
Previous Version								
1	*Critical Illness Benefit Policy*	*HH892012*	*POL*	*Initial*		*46.100*	*HH892012OK.pdf*	*Date Submitted: 10/22/2012 By: Antoinette Hess*
Previous Version								
1	*Critical Illness Benefit Policy*	*HH892012*	*POL*	*Initial*		*46.100*	*LOA HH892012 Critical Illness Policy - Final.pdf*	*Date Submitted: 09/17/2012 By: Antoinette Hess*

No Rate/Rule Schedule items changed.

SERFF Tracking #:	HESS-128670082	**State Tracking #:**		**Company Tracking #:**	AMHLOACIAR

State:	Arkansas	**Filing Company:**	Life Insurance Company of Alabama
TOI/Sub-TOI:	H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness		
Product Name:	Critical Illness		
Project Name/Number:	Individual Specified Disease/AMHLOACIAR		

Conclusion:

In addition to the revised policy form, the outline has also been revised to relfect the changes in the policy.

The Company also noted typographical errors on the applications and are being submitted to replace the existing forms.

Thank you.

Sincerely,

Antoinette Hess

SERFF Tracking #:	*HESS-128670082*	***State Tracking #:***		***Company Tracking #:***	*AMHLOACIAR*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	12/13/2012
Submitted Date	12/13/2012

Dear Donna Lambert,

Introduction:

This is in response to the objection of 11/29/12.

Response 1

Comments:

Please see response to objection dated on the same day.

Changed Items:

SERFF Tracking #:	*HESS-128670082*	***State Tracking #:***		***Company Tracking #:***	*AMHLOACIAR*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Application
Comments:	
Attachment(s):	
MP A&H 2012.pdf MP LIFE 2012.pdf	
Previous Version	
Satisfied - Item:	*Application*
Comments:	
Attachment(s):	
LOA MP AH 2012 ONLY.pdf *LOA MP LIFE 2012 ONLY.pdf*	
Satisfied - Item:	Outline of Coverage
Comments:	The Company is formally withdrawing the Outline of Coverage for the Cancer Policy.
Attachment(s):	
OCHH892012 AR.pdf	
Previous Version	
Satisfied - Item:	*Outline of Coverage*
Comments:	*The Company is formally withdrawing the Outline of Coverage for the Cancer Policy.*
Attachment(s):	
LOA OCHH892012 Outline Critical Illness.pdf	
Previous Version	
Satisfied - Item:	*Outline of Coverage*
Comments:	
Attachment(s):	
LOA OCHH892012 Outline Critical Illness.pdf *OCHC882012 Outline CI Cancer.pdf*	

SERFF Tracking #:	*HESS-128670082*	***State Tracking #:***		***Company Tracking #:***	*AMHLOACIAR*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Application
Comments:	
Attachment(s):	
MP A&H 2012.pdf MP LIFE 2012.pdf	
Previous Version	
Satisfied - Item:	*Application*
Comments:	
Attachment(s):	
LOA MP AH 2012 ONLY.pdf *LOA MP LIFE 2012 ONLY.pdf*	
Satisfied - Item:	Outline of Coverage
Comments:	The Company is formally withdrawing the Outline of Coverage for the Cancer Policy.
Attachment(s):	
OCHH892012 AR.pdf	
Previous Version	
Satisfied - Item:	*Outline of Coverage*
Comments:	*The Company is formally withdrawing the Outline of Coverage for the Cancer Policy.*
Attachment(s):	
LOA OCHH892012 Outline Critical Illness.pdf	
Previous Version	
Satisfied - Item:	*Outline of Coverage*
Comments:	
Attachment(s):	
LOA OCHH892012 Outline Critical Illness.pdf *OCHC882012 Outline CI Cancer.pdf*	

SERFF Tracking #:	*HESS-128670082*	***State Tracking #:***		***Company Tracking #:***	*AMHLOACIAR*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	**Form Name**	**Form Number**	**Form Type**	**Form Action**	**Action Specific Data**	**Readability Score**	**Attachments**	**Submitted**
1	Critical Illness Benefit Policy	HH892012AR	POL	Initial		46.100	HH892012AR.pdf	Date Submitted: 12/13/2012 By: Antoinette Hess
Previous Version								
1	*Critical Illness Benefit Policy*	*HH892012AR*	*POL*	*Initial*		*46.100*	*HH892012AR.pdf*	*Date Submitted: 11/26/2012 By: Antoinette Hess*
Previous Version								
1	*Critical Illness Benefit Policy*	*HH892012*	*POL*	*Initial*		*46.100*	*HH892012OK.pdf*	*Date Submitted: 10/22/2012 By: Antoinette Hess*
Previous Version								
1	*Critical Illness Benefit Policy*	*HH892012*	*POL*	*Initial*		*46.100*	*LOA HH892012 Critical Illness Policy - Final.pdf*	*Date Submitted: 09/17/2012 By: Antoinette Hess*

No Rate/Rule Schedule items changed.

Conclusion:

Thank you.

Sincerely,

Antoinette Hess

SERFF Tracking #:	*HESS-128670082*	***State Tracking #:***		***Company Tracking #:***	*AMHLOACIAR*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/26/2012
Submitted Date	11/26/2012

Dear Donna Lambert,

Introduction:

This is in responseand to follow up on the objection of 9/20/12.

Response 1

Comments:

SERFF Tracking #:	HESS-128670082	**State Tracking #:**	**Company Tracking #:** AMHLOACIAR

State:	Arkansas	**Filing Company:**	Life Insurance Company of Alabama
TOI/Sub-TOI:	H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness		
Product Name:	Critical Illness		
Project Name/Number:	Individual Specified Disease/AMHLOACIAR		

Please note the following:

The Cancer policy was withdrawn for consideration under this filing on 10/22/12 and will be resubmitted upon approval of this policy.

1.The word "must" has been removed for the Notice of Right to Examine Policy.
2.As indicated in my Note To Reviewer of and your Note To Filer - this is a Lump Sum Benefit policy and only pays one time for the Critical Illnesses. There would be no payment for any additional ailments, etc.
3. The parent must take some steps to notify the Company of the child's incapacity as the coverage will automatically end. The information that the company will incur the expense for any proof of incapacity has been added to the provision.
4. As previously explained this is a lump sum policy - it will pay the benefit regardless of care or confinement The statement even after death has been added.
5. Please see Item 2
6. The definition of Legal Spouse now indicates the information with regards to a divorce.
7. The policy now indicates a Covered Person will received this benefit once.
8. Benefits will be available after death.
9. Please see comment under Item 8 with regards to this being a lump sum policy.
10. See Item 8.
11. See Item 8.
12 The policy now indicates the expenses will be at the company's expense.
13. The exclusion has been deleted.
14. Reference to the Right To Conversion has been added to this provision.
15. See Item 3.
16. The language has been revised in the Payment of Premiums provision.
17. Reference to the 180 days has been deleted from the Notice of Claim provision.
18. The amount of $1,000 is now reflected in the Payment of Claims.
19. The objectionable language has been removed from the Contestable provision.
20. The provision has been revised.
21. The provision has been revised.
22. The provision now includes reference to the Right of Conversion provision.

.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #:	*HESS-128670082*	***State Tracking #:***		***Company Tracking #:***	*AMHLOACIAR*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Form Schedule Item Changes:

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Critical Illness Benefit Policy	HH892012AR	POL	Initial		46.100	HH892012AR.pdf	Date Submitted: 11/26/2012 By: Antoinette Hess
Previous Version								
1	*Critical Illness Benefit Policy*	*HH892012*	*POL*	*Initial*		*46.100*	*HH892012OK.pdf*	*Date Submitted: 10/22/2012 By: Antoinette Hess*
Previous Version								
1	*Critical Illness Benefit Policy*	*HH892012*	*POL*	*Initial*		*46.100*	*LOA HH892012 Critical Illness Policy - Final.pdf*	*Date Submitted: 09/17/2012 By: Antoinette Hess*

No Rate/Rule Schedule items changed.

Conclusion:

Thank you.

Sincerely,

Antoinette Hess

SERFF Tracking #:	*HESS-128670082*	***State Tracking #:***		***Company Tracking #:***	*AMHLOACIAR*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/22/2012
Submitted Date	10/22/2012

Dear Donna Lambert,

Introduction:

This is in response to the 2nd objection dated 9/20/12.

Response 1

Comments:

Please see the response under the 1 st response.

Related Objection 1

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Please add the statement required by RR 17 Sec. 8(12) to the first page of the policy.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #:	*HESS-128670082*	***State Tracking #:***		***Company Tracking #:***	*AMHLOACIAR*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Form Schedule Item Changes:

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Critical Illness Benefit Policy	HH892012	POL	Initial		46.100	HH892012OK.pdf	Date Submitted: 10/22/2012 By: Antoinette Hess
Previous Version								
1	*Critical Illness Benefit Policy*	*HH892012*	*POL*	*Initial*		*46.100*	*LOA HH892012 Critical Illness Policy - Final.pdf*	*Date Submitted: 09/17/2012 By: Antoinette Hess*

No Rate/Rule Schedule items changed.

Conclusion:

Thank you.

Sincerely,

Antoinette Hess

SERFF Tracking #:	HESS-128670082	**State Tracking #:**		**Company Tracking #:**	AMHLOACIAR

State:	Arkansas	**Filing Company:**	Life Insurance Company of Alabama
TOI/Sub-TOI:	H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness		
Product Name:	Critical Illness		
Project Name/Number:	Individual Specified Disease/AMHLOACIAR		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/22/2012
Submitted Date	10/22/2012

Dear Donna Lambert,

Introduction:

This is in response to the first objection generated on 9/20/12.

Response 1

Comments:

The Company is withdrawing the Cancer policy and outline of coverage and will submit as a new filing.

Please note the Critical Illness forms have not been revised as the actuaries are reviewing the benefit revisions in conjunction with the rates.

I expect their response within the next few days and will submit revised forms and I am requesting a 5 day extension for the resubmission..

Related Objection 1

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Notice of Right to Examine Policy

Please remove the word must from this paragraph. The word must implies a negative consequence if the company is not notified within 30 days.

Changed Items:

SERFF Tracking #:	*HESS-128670082*	***State Tracking #:***		***Company Tracking #:***	*AMHLOACIAR*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Outline of Coverage
Comments:	The Company is formally withdrawing the Outline of Coverage for the Cancer Policy.
Attachment(s):	
LOA OCHH892012 Outline Critical Illness.pdf	
Previous Version	
Satisfied - Item:	*Outline of Coverage*
Comments:	
Attachment(s):	
LOA OCHH892012 Outline Critical Illness.pdf *OCHC882012 Outline CI Cancer.pdf*	

Form Schedule Item Changes:

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Cancer Benefit Policy	HC882012	POL	Other	Other Explanation : Withdraw	45.000		Date Submitted: 10/22/2012 By: Antoinette Hess
Previous Version								
1	*Cancer Benefit Policy*	*HC882012*	*POL*	*Initial*		*45.000*	*LOA HC882012 Cancer Policy - Final.pdf*	*Date Submitted: 09/17/2012* *By: Antoinette Hess*

No Rate/Rule Schedule items changed.

Response 2

Comments:

See Response 1.

Related Objection 2

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 4, Critical Illness definition - RR 17 Appendix 1A(3) states . . . Specified disease policies shall provide benefits to any covered person not only for the specified disease but also for any other conditions or diseases, directly caused or aggravated by the specified disease or the treatment of the specified disease. Please add this information to the Critical Illness definition.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 3

Comments:

See Response 1.

Related Objection 3

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 4, Dependent Child or Dependent Children - Please remove the sentence requiring proof of incapacity to be received within [XX] days. Bulletin 14-81 1.A does not allow the company to place a time limit on the receipt of notice of the child's incapacity.

The insurer may request proof of incapacity, without placing a time limit on its receipt, if the proof is obtained at the insurers expense. 23-85-131(b)(2). Please add to the provision a statement that proof will be obtained at the company's expense.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 4

Comments:

See Response 1.

Related Objection 4

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: On page 5, the definition of Diagnosed or Diagnosis does not appear to comply with RR 18 Appendix 1.A(9). Benefits must begin the first day of care or confinement even though the diagnosis is made at some later date, provided the diagnosis is made before 90 days after the first day of care or confinement. This would include a diagnosis made after death. Please revise item 3.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 5

Comments:

See Response 1.

Related Objection 5

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: On page 5, the 3rd item in the definition of Incur or Incurred does not appear to comply with RR 18 Appendix 1.A(9). Benefits must begin the first day of care or confinement even though the diagnosis is made at some later date, provided the diagnosis is made before 90 days after the first day of care or confinement. This would include a diagnosis made after death. Please revise this item.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 6

Comments:

See Response 1.

Related Objection 6

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: On page 5, please add to the definition of Legal Spouse that spouse coverage terminates upon divorce subject to the Right of Conversion provision.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 7

Comments:

See Response 1.

Related Objection 7

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: On page 6 in the first paragraph of the Critical Illness Benefits section, the last sentence of the first paragraph states: No Critical Illness Benefit is payable more than once. Does this mean once per individual on a family policy or just once per policy. Please consider adding a statement that clarifies whether or not the benefits will be paid once per individual on a family policy or once per policy. This will make the provision clearer to the insured.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 8

Comments:

See Response 1.

Related Objection 8

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 6, Benefit Payment Conditions. Item (d) does not appear to comply with RR 18 Appendix 1.A(9). Benefits must begin the first day of care or confinement even though the diagnosis is made at some later date, provided the diagnosis is made before 90 days after the first day of care or confinement. This would include a diagnosis made after death. Please revise this item.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 9

Comments:

See Response 1.

Related Objection 9

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 6, Heart Attack. Item 4 does not appear to comply with RR 18 Appendix 1.A(9). Benefits must begin the first day of care or confinement even though the diagnosis is made at some later date, provided the diagnosis is made before 90 days after the first day of care or confinement. This would include a diagnosis made after death. Please revise this item.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 10

Comments:

See Response 1.

Related Objection 10

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 7, Kidney Failure - Please remove from the provision the restriction that the diagnosis must be made during the lifetime of the insured and not post mortem. Benefits must begin the first day of care or confinement even though the diagnosis is made at some later date, provided the diagnosis is made before 90 days after the first day of care or confinement. This would include a diagnosis made after death. Please revise this item. RR 18 Appendix 1.A(9).

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 11

Comments:

See Response 1.

Related Objection 11

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 7, Stroke - Please remove from item 4 the restriction that the diagnosis must be made during the lifetime of the insured and not post mortem. This appears to conflict with RR 18 Appendix 1.A(9). Benefits must begin the first day of care or confinement even though the diagnosis is made at some later date, provided the diagnosis is made before 90 days after the first day of care or confinement. This would include a diagnosis made after death. Please revise this item.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 12

Comments:

See Response 1.

Related Objection 12

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 8, Right to Examine for all Critical Illnesses Please add a statement that the examination will be covered at the companys expense.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 13

Comments:

See Response 1.

Related Objection 13

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 9, Exclusions - Please delete or revise the following exclusion: Any diagnosis made after the death of the Insured.

Changed Items:

No Supporting Documents changed.
No Form Schedule items changed.
No Rate/Rule Schedule items changed.

Response 14

Comments:

See Response 1.

Related Objection 14

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 9, Termination of Insurance Please add to the third paragraph a statement that the termination of the spouses coverage is subject to the Right of Conversion provision.

Changed Items:

No Supporting Documents changed.
No Form Schedule items changed.
No Rate/Rule Schedule items changed.

Response 15

Comments:

See Response 1.

Related Objection 15

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 10 - Please revise or remove the last paragraph of the Termination of Insurance section. Bulletin 14-81 1.A does not allow the company to place a time limit on the receipt of notice of the child's incapacity.

The insurer may request proof of incapacity, without placing a time limit on its receipt, if the proof is obtained at the insurers expense. 23-85-131(b)(2). Please add this information.

Changed Items:

No Supporting Documents changed.
No Form Schedule items changed.
No Rate/Rule Schedule items changed.

Response 16

Comments:

See Response 1.

Related Objection 16

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 11, General Provisions, Payment of Premiums The last sentence of the first paragraph states that refund payments MAY be made to the insured after the companys receipt of the insureds written notice to discontinue coverage. Who would receive the refund if not the insured?

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 17

Comments:

See Response 1.

Related Objection 17

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 12 - Regarding the Notice of Claim provision, ACA 23-85-110 does not allow a time limit for providing notice of claim other than as soon thereafter [60 days] as is reasonably possible. Please remove the 180 day restriction.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 18

Comments:

See Response 1.

Related Objection 18

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 12 - Regarding the Payment of Claims provision, the amount payable cannot be less than $1,000. Since the amount stated ($3,000) is not variable, please clarify in the contract that the company will not pay less than $1,000.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 19

Comments:

See Response 1.

Related Objection 19

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 13, Contestable Period - Please remove:

If We do not receive sufficient documentation from You to properly investigate Your claim that is within this 2 year contestable period, We retain the right to void the Policy and refund all premiums We have received. We will provide You with Written Notice fifteen (15) days before the Policy is voided.

23-85-107, Time Limit on Certain Defenses, does not allow the company to void the policy for this reason.

(In addition, the Contestable Period provision, as it now stands, conflicts with the Date of Diagnosis definition in that the definition states the date of diagnosis means the date [the illness] was first diagnosed,[not] the date the diagnosis [was] communicated to [the insured.] It is possible for the insured to be diagnosed with a Critical Illness but not receive notice of the diagnosis until after the two-year contestability period.)

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 20

Comments:

See Response 1.

Related Objection 20

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 13 - The last sentence of the Contestable Period provision states Misstatements, INCLUDING Fraudulent Misstatements . . . . ONLY Fraudulent misstatements can be used to contest. Please revise this sentence.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 21

Comments:

See Response 1.

Related Objection 21

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 13, Contestable Period - Please add that all statements are representations and not warranties.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 22

Comments:

See Response 1.

Related Objection 22

Applies To:

- Critical Illness Benefit Policy, HH892012 (Form)

Comments: Page 9-10, Termination of Insurance - Please add a statement that the termination of the Dependent Childs coverage is subject to the Right of Conversion provision.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #:	HESS-128670082	**State Tracking #:**		**Company Tracking #:**	AMHLOACIAR

State:	Arkansas	**Filing Company:**	Life Insurance Company of Alabama
TOI/Sub-TOI:	H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness		
Product Name:	Critical Illness		
Project Name/Number:	Individual Specified Disease/AMHLOACIAR		

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Thank you.

Sincerely,

Antoinette Hess

State: Arkansas **Filing Company:** Life Insurance Company of Alabama
TOI/Sub-TOI: H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness
Product Name: Critical Illness
Project Name/Number: Individual Specified Disease/AMHLOACIAR

Note To Filer

Created By:

Donna Lambert on 10/23/2012 10:59 AM

Last Edited By:

Donna Lambert

Submitted On:

12/17/2012 10:09 AM

Subject:

Request for Extension Granted

Comments:

If you need additional time, please let me know.

State: Arkansas **Filing Company:** Life Insurance Company of Alabama
TOI/Sub-TOI: H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness
Product Name: Critical Illness
Project Name/Number: Individual Specified Disease/AMHLOACIAR

Note To Filer

Created By:

Donna Lambert on 10/10/2012 12:48 PM

Last Edited By:

Donna Lambert

Submitted On:

12/17/2012 10:09 AM

Subject:

Thank you for your note

Comments:

Just respond to that particular objection by stating the same information in your Note to Reviewer.

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Note To Reviewer

Created By:

Antoinette Hess on 10/08/2012 01:53 PM

Last Edited By:

Donna Lambert

Submitted On:

12/17/2012 10:09 AM

Subject:

Question on Objection

Comments:

The objection on the forms:
On page 5, the definition of Diagnosed or Diagnosis does not appear to comply with RR 18 Appendix 1.A(9). Benefits must begin the first day of care or confinement even though the diagnosis is made at some later date, provided the diagnosis is made before 90 days after the first day of care or confinement. This would include a diagnosis made after death

What benefits must begin? The policy provides for a lump sum - benefits cannot be paid out for the lump sum amont until the diagnosis is made. The payment will be made after death even if it is diagnosed after 90 days.

Please advise.

Thank you
Toni Hess

SERFF Tracking #:	*HESS-128670082*	***State Tracking #:***		***Company Tracking #:***	*AMHLOACIAR*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Form Schedule

Lead Form Number: HH892012

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved 12/17/2012	Critical Illness Benefit Policy	HH892012AR	POL	Initial		46.100	HH892012AR.pdf
2	Approved 12/17/2012	Cancer Benefit Policy	HC882012	POL	Other	Withdraw	45.000	
3	Approved 09/19/2012	Health Screening Rider	HH89W2012	POLA	Initial		54.500	LOA HH89W2012 Health Screening Rider - Final.pdf
4	Approved 09/19/2012	Health Screening Rider	HC88W2012	POLA	Initial		54.500	LOA HC88W2012 Health Screening Rider - Final.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

LICOA
Life Insurance Company of Alabama
HOME OFFICE • GADSDEN, ALABAMA 35902

Protecting your financial security

CRITICAL ILLNESS BENEFIT POLICY

LIFE INSURANCE COMPANY OF ALABAMA agrees to pay the benefits according to the provisions of this Policy. All benefits are subject to its provisions, exclusions and limitations. This Policy is a legal contract between You and Us.

Signed for the Company at Gadsden, Alabama.

Secretary President

CONSIDERATION

This Policy is issued to You in consideration of Your application and the receipt of the first premium. This Policy is a legal contract between You and Us. Your Policy is effective at 12:01 a.m. on the Effective Date in the time zone of Your home address as indicated on the Policy Schedule page.

NOTICE OF RIGHT TO EXAMINE POLICY

You should read this entire contract carefully and refer to the DEFINITIONS section to understand the meaning of defined words. The application and any amendments or riders are a part of this contract. You must review and give special attention to make sure all of the information in the application and amendments are accurate and complete. You notify Us of any information that is inaccurate, incomplete or omitted within thirty (30) days after delivery of this Policy. You may return this Policy within thirty (30) days after the delivery if You are not satisfied with it for any reason to: Life Insurance Company of Alabama, PO Box 349, Gadsden, AL 35902. The return of this Policy will void it from the Effective Date and any premium We receive will be refunded.

GUARANTEED RENEWABLE TO AGE 90
SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS BY CLASS

You may continue the coverage provided by this Policy by paying all premiums when due, until the Policy anniversary on or following the Expiry Date, subject to the Policy's Termination provision. We reserve the right to change the premium rates for this Policy. Any change in premium will be made on a premium class basis. No change in premium will become effective until 40 days after a notification is sent to Your last known address, on Our Home Office Records.

THIS IS A SPECIFIED DISEASE POLICY, WHICH ONLY PROVIDES BENEFITS FOR THE DIAGNOSIS OF ILLNESSES SPECIFIED AND DEFINED IN THIS POLICY. IT DOES NOT PAY BENEFITS FOR LOSS FROM ANY OTHER CAUSE. THIS POLICY DOES NOT CONTAIN DEATH BENEFITS. IT CONTAINS WAITING PERIODS EXCLUSIONS AND LIMITATIONS.

THIS IS A LIMITED BENEFIT POLICY
READ IT CAREFULLY WITH THE OUTLINE OF COVERAGE

TABLE OF CONTENTS

POLICY SCHEDULE **[policy no]**

FORM NO.	DESCRIPTION	UNITS	PLAN	PREMIUM
[HH89]	[CRITICAL ILLNESS]	[XXX.XXX]	[HH89]	[$XXX.XX]

TOTAL ANNUAL PREMIUM **[$XXX.XX]**

RENEWAL PREMIUMS

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY
[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]

***THE FOLLOWING BENEFITS ARE PAID FOR COVERAGE PROVIDED BY*:**

1. **[CRITICAL ILLNESS BENEFITS** **BENEFIT AMOUNT (Based On XXX.XXX Units)**

	Primary Insured	Spouse	Per Child
Heart Attack	$ XXX	$ XXX	$ XXX
Coronary Artery Bypass Grafting	$ XXX	$ XXX	$ XXX
Coronary Artery Angioplasty	$ XXX	$ XXX	$ XXX
Stroke	$ XXX	$ XXX	$ XXX
Kidney Failure	$ XXX	$ XXX	$ XXX
Major Organ Transplant	$ XXX	$ XXX	$ XXX
CRITICAL ILLNESS BENEFIT MAXIMUM	$ XXX	$ XXX	$ XXX]

On a Covered Person's attained age 70, all Critical Illness Benefits and the Critical Illness Benefit Maximum, less any benefits previously paid, will be reduced by one-half (50%), for that Covered Person.

2. **[Optional Rider[(s)]]**

POLICY NUMBER:
[xxxxxxxxxx]

INSURED:
[John Doe]
[123 WALKING WAY]
[ANYTOWN, AL, 12345]

EFFECTIVE DATE:
[MM/DD/YYYY]

ISSUE AGE: [XX] SEX:[MALE]
SMOKING STATUS: [NON-SMOKER]
POLICY WAITING PERIOD: [30 days for all Benefits]

PREMIUM: [$XXX.XX]
PAYABLE EVERY: [MONTH]
COVERAGE TYPE: [INDIVIDUAL]

DEFINITIONS

As used in, and for the purposes of this Policy, the terms listed below will have the meanings as defined. The plural use of a term will share the same meaning as the singular.

AGE means the attained age as of the Covered Person's last birthday.

CLINICAL DIAGNOSIS means a Diagnosis and identification of a Covered Event or Covered Condition based on observation and history, diagnostic and laboratory studies, and symptoms.

COVERED EVENT or COVERED CONDITION means Heart Attack, Kidney Failure, Stroke, Major Organ Transplant, Coronary Artery Angioplasty, and Coronary Artery Bypass Grafting as each is defined in this Policy, including any applicable limitations and exclusions.

COVERED PERSONS are indicated by the Coverage Type as shown on the Policy Schedule Page as follows:

1) Individual: Only the Primary Insured listed on the Policy Schedule Page is covered.
2) Individual and Spouse: The Primary Insured and the Primary Insured's Legal Spouse as listed on the application or added/changed by endorsement are covered.
3) One Parent Family: The Primary Insured and all of the Primary Insured's legal Dependent Child(ren) as listed on the application or added/changed by endorsement are covered.
4) Two Parent Family: The Primary Insured, the Primary Insured's Legal Spouse as listed on the application or added/changed by endorsement and all of the Primary Insured's legal Dependent Child(ren) as listed on the application or added/changed by endorsement are covered.

Any person specifically excluded by name from coverage is NOT included as a Covered Person.

CRITICAL ILLNESS means only the illnesses or procedures listed in the Policy Schedule under "Critical Illness Benefits"

CRITICAL ILLNESS BENEFIT MAXIMUM means the maximum total dollar amount payable under this Policy stated in the Policy Schedule. The Critical Illness Benefit Maximum is reduced, for all Covered Persons, by fifty percent (50%) on the Covered Person's attained age of 70 years.

DATE OF DIAGNOSIS means the date the Covered Event or Covered Condition of a Critical Illness is first Diagnosed. It is NOT the date the Diagnosis is communicated to a Covered Person.

DEPENDENT CHILD OR DEPENDENT CHILDREN means any unmarried child (natural, step or adopted) of Yours who:

1) is less than nineteen (19) years old and living with You; or
2) is less than twenty-four (24) years old and attending an accredited school as a full time student. Such child must be legally dependent upon You for principal support and maintenance; or
3) is or becomes incapable of self-support because of mental or physical handicap while covered under this Policy and prior to attaining limiting age for Dependent Child(ren) under (1) or (2) above. The child must be legally dependent upon You for support and maintenance. We must receive proof of incapacity after coverage would otherwise terminate. Coverage will then continue as long as Your insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age twenty-four (24) at the Company's expense; or
4) is not living with You, but You are legally required to support such child, and the child would otherwise qualify under (1), (2) or (3) above.

The term Dependent Child(ren) does NOT include grandchild(ren) unless required by law.
Proof of legal status may be required from time to time on covered Dependent Child(ren).

DEFINITIONS (Continued)

DIAGNOSED or **DIAGNOSIS** means a definitive identification of the Critical Illness made by a Physician (where applicable, specializing in a particular area of medicine) and supported by documentation of all appropriate and defined studies:

1. based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
2. meets any diagnostic requirements stated in this Policy for the particular Critical Illness being diagnosed; and
3. performed during the lifetime of the Covered Person and includes a diagnosis after death.

EFFECTIVE DATE means the date that this Policy becomes effective. The Effective Date is stated on the Policy schedule page.

FRAUDULENT MISREPRESENTATIONS means information on the application that is stated incorrectly for the purposes of obtaining this Policy.

IMMEDIATE FAMILY OR **IMMEDIATE FAMILY MEMBER** includes anyone related to You or Your Legal Spouse in the following manner: spouse; brothers or sisters (including stepbrothers, stepsisters, half-brothers and half-sisters);children (including stepchildren); parents (including stepparents); grandparents (including step grandparents);grandchildren (including step-grandchildren); aunts and uncles; nieces and nephews; and spouses, as applicable, of any of the above.

INCUR or INCURRED means an event, incident, or condition that:
1. occurs on or after the Effective Date of this Policy, and
2. occurs while this Policy is in force, and
3. is Diagnosed during the life of the Covered Person and after death, and
4. is not specifically excluded by any definitions or exclusions in this Policy.

LEGAL SPOUSE means Your spouse as recognized by federal law. Once this Policy has been issued, any consideration of an addition of a spouse, whether by first marriage or remarriage, requires the submission of a completed application and is subject to Our approval. Spouse coverage terminates upon divorce of marriage. Proof of legal status may be required upon Our request from time to time on a covered spouse.

MANIFESTS or MANIFESTED means a condition or symptom that would cause an ordinary prudent person to seek medical advice, care, or treatment.

MONTH means a calendar month.

PHYSICIAN means a person who:
1. is a legally qualified medical practitioner in good standing and a Doctorate of the healing arts licensed in the United States or its territories; and
2. practices within the scope of his or her license and specialty in the United States or its territories; and
3. is not the Covered Person; or
4. is not the Covered Person’s Immediate Family Member or business associate; or
5. does not customarily reside in the same household as the Covered Person.

A Physician does NOT mean an emergency medical technician, nurse, nurse practitioner, physician’s assistant, coroner or other medical personnel that does not meet the above qualifications.

PRIMARY INSURED means the person named in the Policy Schedule Page.

DEFINITIONS (Continued)

REINSTATEMENT DATE means the date coverage under this Policy and any attached Riders becomes effective following Reinstatement. This date will be the date of Our approval in writing of the reinstatement of any coverage.

WE, OUR, COMPANY or US means Life Insurance Company of Alabama

YOU or YOUR refers to the Primary Insured named in the Policy Schedule.

CRITICAL ILLNESS BENEFITS

We will pay the Critical Illness Benefit amount stated in the Policy Schedule (subject to all applicable Policy provisions), if a Critical Illness is both Incurred (or Manifests, as stated in the Policy), and is Diagnosed more than 30 days after the Effective Date. Payment of the Primary Insured's Critical Illness Benefit Maximum terminates this Policy. Payment of the Critical Illness Benefit Maximum for a Covered Person terminates coverage for that Covered Person. The Critical Illness Benefit Maximum for a Covered Person is reduced by the amount of all Critical Illness Benefit amounts paid for that Covered Person. The total of all Critical Illness Benefit payments for a Covered Person cannot exceed the Critical Illness Benefit Maximum for that Covered Person as stated in the Policy Schedule. No Critical Illness Benefit for a Covered Person is payable more than once.

On a Covered Person's attained age 70, all Critical Illness Benefits and the Critical Illness Benefit Maximum, less any benefits previously paid, will be reduced by one-half (50%), for that Covered Person.

BENEFIT PAYMENT CONDITIONS

The payment of benefits for a Critical Illness stated in the Policy Schedule is subject to the following conditions:

(a) the Critical Illness Incurs and/or Manifests as stated in the Policy; and

(b) the Critical Illness is Diagnosed, Incurred and Manifested after the Policy Waiting Period following the Effective date of this Policy; and

(c) the benefit payment is not excluded by any general or specific exclusion or limitation; and

(d) the Critical Illness Diagnosis is made by a legally licensed Physician during the lifetime of the Insured and includes after death.

(e) All required Proofs of Loss must be received by the Company.

CRITICAL ILLNESS BENEFITS (Continued)

HEART ATTACK

For the purposes of this Policy, Heart Attack means an Acute Myocardial Infarction resulting in death of heart muscle due to inadequate blood supply. .

All of the following criteria for acute myocardial infarction must be satisfied:

1. Medical documentation of typical clinical symptoms, for example, central chest pain; and
2. diagnostic increase of specific cardiac markers or elevated cardiac enzymes; and
3. new electrocardiographic changes consistent with an Acute Myocardial Infarction; and
4. the Critical Illness Diagnosis of an Acute Myocardial Infarction must be made by a legally licensed Physician during the Covered Person's lifetime and includes after death.

Heart Attack does **not** mean a cardiac arrest, congestive heart failure, cardiopulmonary arrest or any condition other than an Acute Myocardial Infarction.

If a Heart Attack is Incurred, Manifested and Diagnosed more than 30 days after the Effective Date, We will pay the Heart Attack Benefit stated in the Policy schedule.

Heart Attack that is Incurred during or within 24 hours of any heart, cardiac or coronary artery medical procedure is excluded.

KIDNEY FAILURE

For the purposes of this Policy, Kidney Failure means chronic irreversible failure of **both** kidneys to function, as a result of which either regular renal or peritoneal dialysis, or renal transplant is initiated. The Critical Illness Diagnosis must be made by a legally licensed Physician during the Covered Person's lifetime and includes after death.

KIDNEY FAILURE BENEFIT

If Kidney Failure both Manifests and is Diagnosed more than 30 days after the Effective Date, We will pay the Kidney Failure Benefit stated in the Policy Schedule.

STROKE

For the purposes of this Policy, Stroke means death of brain tissue due to an acute cerebrovascular event. All of the following criteria for stroke must be satisfied:

1. clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage; and
2. clear evidence on a CT, MRI or similar imaging technique that a stroke has occurred; and
3. permanent neurologic deficit measured 30 days or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome; and
4. the Critical Illness Diagnosis must be made by a legally licensed Physician during the Covered Person's lifetime and includes after death.

Symptoms due to and conditions of transient ischemic attack, migraine, hypoxia, traumatic injury to brain tissue or blood vessels, and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

STROKE BENEFIT

If a Stroke is Incurred, Manifested and Diagnosed more than 30 days after the Effective Date, We will pay the Stroke Benefit stated in the Policy Schedule.

MAJOR ORGAN TRANSPLANT

For the purposes of this Policy, Major Organ Transplant means human to human organ transplant from a donor to the Covered Person of: bone marrow (solely for treatment of cancer or bone marrow failure), or transplant of an entire kidney, liver, heart, lung, or pancreas. Transplant of any other organs, parts of organs, tissues or cells are excluded.

MAJOR ORGAN TRANSPLANT BENEFIT

We will pay the Major Organ Transplant Benefit stated in the Policy schedule, if more than 30 days after the Effective Date both:

(a) the need for a Major Organ Transplant is first Diagnosed; and
(b) the Covered Person undergoes a Major Organ Transplant.

CORONARY ARTERY ANGIOPLASTY

For the purposes of this Policy, Coronary Artery Angioplasty means balloon angioplasty; laser angioplasty; angioplasty and stent placement; or atherectomy; to correct narrowing or blockage of one or more coronary arteries.

CORONARY ARTERY ANGIOPLASTY BENEFIT

We will pay the Coronary Artery Angioplasty Benefit stated in the Policy schedule if, more than 30 days after the Effective Date both:

(a) the need for a Coronary Artery Angioplasty is first Diagnosed; and
(b) the Covered Person undergoes a Coronary Artery Angioplasty.

All diagnostic procedures including, but not limited to, arteriograms, angiograms and cardiac catheterization are excluded.

This benefit is payable only once in the Covered Person's lifetime.

CORONARY ARTERY BYPASS GRAFTING

For the purposes of this Policy, Coronary Artery Bypass Grafting means major open heart surgery requiring median sternotomy (division of the breast bone) to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Procedures that do not require median sternotomy are excluded, including but not limited to, minimally invasive, endoscopic, and "keyhole" heart surgery; balloon and laser angioplasty; stent procedures; and atherectomy.

CORONARY ARTERY BYPASS GRAFTING BENEFIT

We will pay the Coronary Artery Bypass Grafting Benefit stated in the Policy schedule if, more than 30 days after the Effective Date both:

(a) the need for Coronary Artery Bypass Grafting is first Diagnosed; and
(b) the Covered Person undergoes Coronary Artery Bypass Grafting.

This benefit is payable only once in the Covered Person's lifetime**.**

RIGHT TO EXAMINE FOR ALL CRITICAL ILLNESSES

We reserve the right to conduct a physical examination of the Covered Person and/or review any Critical Illness Diagnosed by a Physician of Our choosing. Any expenses incurred for this examination will be paid by the Company. This Physician must:

(a) have specialty training and board certification in the field of Medicine specific to the Critical Illness being Diagnosed; and

(b) must follow all routinely accepted procedures and protocols in the Diagnosis of the Critical Illness.

EXCLUSIONS

We will NOT pay benefits for a loss while being, caused by, contributed to, or resulting from:

- Any act of war, declared or undeclared; or
- Active duty in the armed forces, National Guard, or any reserve unit; or
- Engaging in a felony, or participating in any riot or civil insurrection; or
- Engaging in an illegal activity; or participating in any riot or civil insurrection; or
- Any intentionally self-inflicted injury; suicide, or suicide attempt; or
- Under the influence of alcohol (including the operation of or passenger of a motor vehicle with a blood alcohol concentration in excess of the legal limit of the state in which the accident occurs) or a controlled substance unless legally prescribed and used in the manner consistent with that prescription; or
- Any benefits for conditions diagnosed outside of the United States unless the Diagnosis and Date of Diagnosis can be confirmed in the United States by a Physician; or
- Any illness, loss, or condition specifically excluded from the definition of any Critical Illness; or
- Any illness, loss, or condition not stated as a covered Critical Illness in this Policy; or
- Any Critical Illness in which ALL of the criteria and Proof of Loss has not been received by the Company.

TERMINATION OF INSURANCE

Insurance coverage for You and Your Legal Spouse, if covered, will continue until the earliest of:

1) the Primary Insured's 90th birthday; or
2) the date any premium for this Policy is in default beyond the end of its Grace Period; or
3) the premium due date following Your written request for its termination.

In the event of Your death, coverage on any remaining Covered Persons will not terminate provided We receive a copy of Your death certificate and Written Notice to continue coverage within thirty (30) days of the date of Your death. If Your covered Legal Spouse or Dependent Child dies, You may request in writing to remove them from Your coverage.

If Your Legal Spouse is a Covered Person under this Policy and You and Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage, insurance coverage provided by this Policy on Your former Legal Spouse will automatically terminate on the 61st day following the date of the decree of the dissolution of marriage subject to the Right of Conversion provision.

Insurance coverage on a Dependent Child will terminate automatically on the earliest of the following:

1) the date of the Dependent Child's marriage; or
2) the Dependent Child's nineteenth (19th) birthday, if not a full-time student at an accredited school; or
3) the Dependent Child's twenty-fourth (24th) birthday, if a full-time student at an accredited school and legally dependent on You for principal support and maintenance.

Insurance coverage will not terminate due to the Dependent Child's age if the child is both:

1) incapable of self-sustaining employment because of mental or physical handicap; and
2) currently dependent upon You for support and maintenance.

You ***must*** provide proof of the Dependent Child's mental or physical handicap and dependence upon You after coverage would otherwise terminate in order for coverage to continue under this Policy. Proof of continued incapacity and dependency ***must be*** furnished at Our request.

Termination of Dependents is subject to the Right of Conversion provision.

RIGHT OF CONVERSION

If You and Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage and Your Legal Spouse was a Covered Person under this Policy, then Your former Legal Spouse may apply and receive, without evidence of insurability, a Policy providing coverage NOT greater than the terminated coverage. To obtain the Policy, Your former Legal Spouse must make application to Us within sixty (60) days following the date of the decree of dissolution of marriage. The Primary Insured under this Policy at the time of the dissolution of marriage shall remain the Primary Insured under this Policy. Coverage terminates automatically for the former Legal Spouse on the 61st day following the date of the decree of the dissolution of marriage. Any covered Dependent Children may be covered under either Policy, but NOT both.

A Covered Person whose dependency terminates and who desires to continue coverage as a Primary Insured under a separate Policy may do so by notifying Us of the request in writing. The Dependent Child will have the right to continue coverage as the Primary Insured under a separate Policy providing coverage NOT greater than the previous coverage without a requirement for evidence of insurability and without interruption in coverage. To obtain the Policy, the Dependent Child must make application to Us after the termination of insurance under this Policy.

In order to be considered for coverage, any Legal Spouse or Dependent Child not listed on the initial application must make written application.

GENERAL PROVISIONS

ENTIRE CONTRACT

This Policy, with the attached application, any other pages, amendments, or endorsements attached, and any application for reinstatement, are the entire contract between You and Us. This contract is made in consideration of Your application and payment of premiums as required. We rely on all statements in the application and any application for reinstatement as being true to the best of Your knowledge. No change to this Policy will be valid unless it is in writing and signed by an authorized Officer of Life Insurance Company of Alabama. No agent or other representative has authority to change or waive any Policy provisions or extend the time for paying a premium.

PAYMENT OF PREMIUMS

The due date of the initial premium is the Policy Effective Date. The initial premium may be paid to Our Home Office or to one of the Company's authorized agents. Premiums after the initial premium must be paid to Our Home Office at P.O. Box 349, Gadsden, AL 35902. Upon receipt of Your death certificate, We will refund any premium paid for any monthly period following the date of death. The refund may be paid to Your estate or designated Beneficiary. Upon receipt of Your written notice to discontinue coverage, We will refund any premium paid for any monthly period following the date We received the written notice from You. The refund may be paid to You.

This Policy is not effective until the Effective Date regardless of the date of the first premium payment if any premium is paid prior to the Effective Date. Any premium received prior to issue of the Policy will be held pending issue of the Policy. If the Policy is not issued by Us, We will refund any premium being held. If We or any third party on Our behalf receive premiums by any method (including payroll deduction and bank draft) prior to the issue of this Policy, We assume NO liability for coverage until this Policy is issued by Us. Premiums must be paid in United States currency.

GRACE PERIOD

This Policy has a thirty (30) day Grace Period for paying premium. This means if a renewal premium is not paid by the date due, it may be paid during the following thirty (30) days. Any otherwise payable claim incurred during the Grace Period will NOT be paid until the past due premiums are paid provided the Policy has not lapsed or terminated.

LAPSE

Your Policy will lapse if any premium is not paid before the end of the Grace Period. The date of lapse will be the date that the unpaid premium was due. Your Policy will terminate upon lapse as of the last date to which premiums have been paid and provide NO further benefits.

GENERAL PROVISIONS (Continued)

REINSTATEMENT

If Your Policy lapses, You may request to reinstate it by:

1. submitting a written application for reinstatement within 60 days after the end of the Grace Period; and
2. providing any additional evidence of insurability as We may require; and
3. paying all required premium.

If We approve Your request for reinstatement, coverage will become effective as of the Reinstatement Date. Unless we have previously sent you a written notice of disapproval, the Policy will be reinstated on the 45th day after Our receipt of the required evidence of insurability or such earlier date that We approve such evidence.

We will not pay benefits for any Critical Illness that Incurs or Manifests, whichever is applicable as stated in this Policy, and/or is Diagnosed: before the end of 30 days after the Reinstatement Date.

Your rights and Our obligations under this Policy will be the same as before the Policy lapsed subject to the Reinstatement and Incontestable provisions.

If You do not request a reinstatement within 90 days from the date any unpaid premium was due, this Policy will remain terminated and no further benefits will be provided.

UNEARNED PREMIUM REFUND

If You die before the end of a Premium Period for which premium has been paid, We will refund the portion of premium, prorated monthly, that was applied to coverage for the time period beyond the end of the month in which death occurred.

NOTICE OF CLAIM

You must provide Us with written notice of claim within 60 days from the Date of Diagnosis, or as soon as reasonably possible. You must provide notice of claim at Our Home Office. Your notice of claim must include the Covered Person, Your name, address, the Policy Number, and the Covered Condition or Covered Event for which the Covered Personis claiming

CLAIM FORMS

When We receive Your notice of claim, we will provide You with the forms required to file a claim. If you do not receive the forms within 15 days, You will have met the time frame required for filing Your claim. if You have provided Us with a written statement of the nature and extent of Your loss and sufficient Proof of Loss within the time allowed for filing a Proof of Loss.

PROOF OF LOSS

You must provide Us with written Proof of Loss determined to be satisfactory to Us within 90 days from the Date of Diagnosis. If it is not reasonably possible for You to provide written Proof of Loss within the stated time, Your claim will not be affected if You provide the written Proof of Loss as soon as reasonably possible but in no event later than 12 months from the Date of Diagnosis.

Proof of Loss includes the claim form (or written statement as noted in Claim Forms section above), plus appropriate evidence needed to establish benefit eligibility, which may include, but not limited to, physician or hospital records, histo-pathological reports, operative reports and test reports.

You must provide to Us any authorizations to obtain medical records or other information needed to evaluate your claim.

TIME OF PAYMENT OF CLAIMS

We will pay benefits within thirty (30) working days once We receive sufficient written Proof of Loss. If We do not pay benefits upon receipt of your claim, We shall have thirty (30) working days thereafter within which to mail to You a letter or notice which states the reasons We have for not paying the claim, either in whole or in part, and which also gives You a notice of any documents or other information needed to process the claim. When We have received sufficient written Proof of Loss from You, We shall then have thirty (30) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

PAYMENT OF CLAIMS

We will pay all benefits to You; benefits under this Policy are not subject to assignment. Upon receipt of Your death certificate, any benefits that have not been paid at the time of Your death may be paid to Your estate or Your designated Beneficiary. We have the right to pay up to $1,000 of those benefits to any Immediate Family Member who We believe is justly entitled to such payment. If We make a payment under this provision in good faith, We will be released from liability to the extent of the payment.

LEGAL ACTIONS

No legal action may be brought to recover benefits on this Policy before 60 days after We have received sufficient written Proof of Loss. No legal action may be brought against us more than two (2) years from the date written Proof of Loss was required to be provided.

AGE AND GENDER

If a Covered Person's Age or Gender is not correct as shown in this Policy, all benefits payable under this Policy will be such as the premium paid would have purchased at the correct Age or Gender. If the correct age is such that we would have obtained additional underwriting requirements or would not have issued this Policy, We will only be liable for a refund of any premiums paid for the period for which there was no coverage.

CONTESTABLE PERIOD

After two (2) years from the Effective Date (or the Reinstatement Date, if the Policy has been reinstated), only Fraudulent Misstatements, made by You in the application (or reinstatement application) shall be used to void this Policy or to deny a claim with a Date of Diagnosis after the expiration of such two (2) year contestable period. The Date of Diagnosis determines whether or not a claim is within the Contestable Period, NOT when the claim is received by Us. Only Fraudulent Misstatements, made by You on the Application (or reinstatement application) may be used by Us to void this Policy or to deny a claim with a Date of Diagnosis within two (2) years after the Effective Date or within two (2) years after the Reinstatement of this Policy.

EFFECTIVE DATE

This Policy's Effective Date is the date shown on the Policy Schedule. This Policy will take effect at 12:01 AM in the time zone of Your last known address, on our Home Office records on the Effective Date. This Policy will terminate at 11:59 PM in the time zone of Your last known address, on our Home Office records on the date of termination. If this Policy lapses and is reinstated, the Effective Date is as described in the Reinstatement Provision.

GENERAL PROVISIONS (Continued)

TERMINATION

This Policy will terminate on the earliest of:

(a) the date on which this Policy lapses or terminates; or
(b) the date that the Primary Insured's Critical Illness Benefit Maximum is paid; or
(c) any premium due date requested by You in writing to terminate this Policy; or
(d) the end of the Grace Period following the due date for which a premium was not paid; or
(e) the death of the Primary Insured; or
(f) The Primary Insured's age 90.

OWNER

The Insured is the Owner of this Policy unless later changed.

As Owner, You may exercise all rights in this Policy while the Insured Person is living. If You are without legal capacity, We will allow Your rights to be exercised by:

(a) a legally appointed Guardian responsible for Your property; or
(b) a person who We determine is responsible for Your welfare and support.

To exercise Your rights, You must follow the procedures stated in this Policy. All elections, designations, changes and requests must be made in writing and in a form acceptable to Us.

If You change Your beneficiary, address, or request any other action by Us, You should do so on the form prepared for each purpose. You may obtain such forms from Our Home Office at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, AL 35902.

BENEFICIARY

The beneficiary designated by You in the application or later changed on Our records will receive any benefits unpaid at Your death. Each beneficiary is classified as a Primary or Contingent Beneficiary. All surviving beneficiaries of the same class will share equally in any payments to that class, unless otherwise designated by You.

If no stated beneficiary is living at the time of Your Death, We will pay:

(a) the executor or administrator of Your estate; or
(b) Your spouse, child, or parent who We determine is entitled to payment

CHANGE OF OWNER OR BENEFICIARY

While the Insured Person is living, You may change:

(a) the Owner; or
(b) a Beneficiary designation, if it is not restricted by a previous designation.

We require that any change be endorsed by an authorized Officer of Our Company. Any change will be effective the date of Our endorsement. No agent or other representative has authority to endorse this Policy.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy that, on the coverage effective date, conflicts with any laws of the state where You lived when this Policy was issued, is amended to conform with the law.

LIFE INSURANCE COMPANY OF ALABAMA
P.O. Box 349
Gadsden, Alabama 35902

HEALTH SCREENING RIDER

We will provide the Indemnity Benefits stated in this Rider, subject to the terms and conditions contained in this Rider and in the Policy to which it is attached. Terms and definitions for this Rider are the same as used in the Policy to which this Rider is attached except when explicitly stated in this Rider.

RIDER RENEWAL PROVISION

This Rider is Guaranteed Renewable during Your lifetime. We retain the right to change the applicable table of premium rates for this Rider as provided on the first page of the Policy.

BENEFITS

Indemnity Benefit

We will pay the Indemnity Benefit as shown on the Policy Schedule Page. The Indemnity Benefit occurs when one (1) of the listed health screening tests specified below is ordered and performed on a Covered Person. We will pay this benefit regardless of the results of the test.

Health Screening Tests

CAT Scan	Electrocardiogram
MRI (magnetic resonance imaging)	Chest X-Ray
Heart Catheterization	Echocardiograms
Neuroimaging Studies	Blood tests to confirm elevated cardiac enzymes
Thallium Scan	Angiograms

The Indemnity Benefit is payable only once per calendar year per Covered Person.

GENERAL PROVISIONS

The following provisions apply to this Rider:

1) this Rider is made part of the Policy to which it is attached; and
2) benefits are subject to all the provisions of this Rider and the Policy to which it is attached; and
3) the Rider Effective Date is as shown on the Policy Schedule Page; and
4) the premium for this Rider is as shown on the Policy Schedule Page.

TERMINATION OF RIDER

This Rider terminates at the earliest of:

1) the date the Policy is terminated for any reason; or
2) the date any premium for this Rider or the Policy is in default beyond the end of its Grace Period; or
3) the premium due date following Your written request for its termination.

Signed for the Company at its Home Office.

Secretary

President

LIFE INSURANCE COMPANY OF ALABAMA
P.O. Box 349
Gadsden, Alabama 35902

HEALTH SCREENING RIDER

We will provide the Indemnity Benefits stated in this Rider, subject to the terms and conditions contained in this Rider and in the Policy to which it is attached. Terms and definitions for this Rider are the same as used in the Policy to which this Rider is attached except when explicitly stated in this Rider.

RIDER RENEWAL PROVISION

This Rider is Guaranteed Renewable during Your lifetime. We retain the right to change the applicable table of premium rates for this Rider as provided on the first page of the Policy.

BENEFITS

Indemnity Benefit

We will pay the Indemnity Benefit as shown on the Policy Schedule Page. The Indemnity Benefit occurs when one (1) of the listed health screening tests specified below is ordered and performed on a Covered Person. We will pay this benefit regardless of the results of the test.

Health Screening Tests

Biopsy	Hemoccult Stool Specimen (lab confirmed)
Breast MRI (magnetic resonance imaging)	Mammogram
Breast Ultrasound	Pap Smear
CA 125 (blood test for ovarian Cancer)	PSA (blood test for prostate Cancer)
CA 15-3 (blood test for breast Cancer tumor)	Serum Protein Electrophoresis
CEA (blood test for colon Cancer)	Testicular Ultrasound
Chest X-ray	Thermography
Colonoscopy	Thin Prep
Flexible Sigmoidoscopy	Virtual Colonoscopy

The Indemnity Benefit is payable only once per calendar year per Covered Person.

GENERAL PROVISIONS

The following provisions apply to this Rider:

1) this Rider is made part of the Policy to which it is attached; and
2) benefits are subject to all the provisions of this Rider and the Policy to which it is attached; and
3) the Rider Effective Date is as shown on the Policy Schedule Page; and
4) the premium for this Rider is as shown on the Policy Schedule Page.

TERMINATION OF RIDER

This Rider terminates at the earliest of:

1) the date the Policy is terminated for any reason; or
2) the date any premium for this Rider or the Policy is in default beyond the end of its Grace Period; or
3) the premium due date following Your written request for its termination.

Signed for the Company at its Home Office.

Secretary

President

SERFF Tracking #:	*HESS-128670082*	***State Tracking #:***		***Company Tracking #:***	*AMHLOACIAR*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Rate Information

Rate data applies to filing.

Filing Method:	SERFF
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	0.000%
Effective Date of Last Rate Revision:	
Filing Method of Last Filing:	NA

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Life Insurance Company of Alabama	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking #:	*HESS-128670082*	***State Tracking #:***		***Company Tracking #:***	*AMHLOACIAR*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1	Approved 12/17/2012	Rate Pages	HH892012, HC882012, HH89W2012, HC88W2012	New		LOA Rate Pages.pdf

Life Insurance Company of Alabama
Critical Illness Benefit Policy
Policy Form HH892012
Monthly Issue Age Premium Rates per 1,000

Primay Insured Only

	Guaranteed Issue or "EZ" Underwriting				Full Underwriting			
	Tobacco		Non-Tobacco		Tobacco		Non-Tobacco	
Issue Age	Male	Female	Male	Female	Male	Female	Male	Female
18-24	0.2763	0.1770	0.1968	0.1493	0.2013	0.1123	0.1300	0.0876
25-29	0.4191	0.2377	0.2698	0.1874	0.3305	0.1679	0.1966	0.1230
30-34	0.6832	0.3556	0.4065	0.2638	0.5638	0.2696	0.3155	0.1873
35-39	1.0874	0.5350	0.6067	0.3757	0.9200	0.4253	0.4896	0.2824
40-44	1.7389	0.8303	0.9275	0.5610	1.5074	0.6757	0.7634	0.4341
45-49	2.5177	1.1957	1.3115	0.7877	2.2151	0.9940	1.1000	0.6288
50-54	3.3595	1.6302	1.7335	1.0529	2.9992	1.3945	1.4904	0.8682
55-59	4.2962	2.1481	2.2099	1.3751	3.8575	1.8628	1.9217	1.1485
60-64	5.2258	2.7131	2.6880	1.7217	4.7307	2.3917	2.3713	1.4742
65-69	5.6388	3.0837	2.9270	1.9648	5.1285	2.7383	2.5898	1.6925

Primary Insured + Spouse

	Guaranteed Issue or "EZ" Underwriting				Full Underwriting			
	Tobacco		Non-Tobacco		Tobacco		Non-Tobacco	
Issue Age	Male	Female	Male	Female	Male	Female	Male	Female
18-24	0.3256	0.2766	0.2330	0.2093	0.2440	0.1996	0.1601	0.1390
25-29	0.4978	0.4077	0.3246	0.2837	0.4000	0.3189	0.2439	0.2072
30-34	0.8174	0.6530	0.4952	0.4247	0.6836	0.5364	0.3939	0.3305
35-39	1.3095	1.0325	0.7474	0.6323	1.1230	0.8702	0.6153	0.5120
40-44	2.1008	1.6444	1.1532	0.9685	1.8404	1.4188	0.9641	0.8000
45-49	3.0537	2.3917	1.6451	1.3824	2.7155	2.0998	1.4085	1.1669
50-54	4.1113	3.2467	2.1984	1.8591	3.6911	2.8946	1.9199	1.6049
55-59	5.3030	4.2257	2.8292	2.4105	4.7913	3.7919	2.4961	2.1089
60-64	6.5098	5.2555	3.4777	2.9995	5.9271	4.7528	3.1096	2.6596
65-69	7.1057	5.8290	3.8327	3.3528	6.4976	5.3061	3.4368	2.9889

Primary Insured + Child(ren)

	Guaranteed Issue or "EZ" Underwriting				Full Underwriting			
	Tobacco		Non-Tobacco		Tobacco		Non-Tobacco	
Issue Age	Male	Female	Male	Female	Male	Female	Male	Female
18-24	0.2874	0.1890	0.2085	0.1614	0.2097	0.1207	0.1383	0.0960
25-29	0.4308	0.2506	0.2822	0.2004	0.3398	0.1774	0.2060	0.1323
30-34	0.6955	0.3683	0.4197	0.2772	0.5739	0.2792	0.3256	0.1971
35-39	1.0993	0.5468	0.6191	0.3891	0.9310	0.4347	0.4996	0.2925
40-44	1.7528	0.8403	0.9399	0.5733	1.5195	0.6852	0.7736	0.4436
45-49	2.5278	1.2053	1.3224	0.7982	2.2284	1.0039	1.1110	0.6376
50-54	3.3707	1.6368	1.7422	1.0617	3.0052	1.4029	1.4993	0.8752
55-59	4.3048	2.1553	2.2187	1.3833	3.8652	1.8703	1.9294	1.1554
60-64	5.2338	2.7185	2.6969	1.7303	4.7336	2.4013	2.3760	1.4801
65-69	5.6482	3.0889	2.9328	1.9727	5.1388	2.7438	2.6002	1.6967

Family

	Guaranteed Issue or "EZ" Underwriting				Full Underwriting			
	Tobacco		Non-Tobacco		Tobacco		Non-Tobacco	
Issue Age	Male	Female	Male	Female	Male	Female	Male	Female
18-24	0.3373	0.2873	0.2442	0.2203	0.2543	0.2096	0.1703	0.1490
25-29	0.5107	0.4202	0.3370	0.2956	0.4113	0.3298	0.2552	0.2180
30-34	0.8309	0.6662	0.5092	0.4375	0.6959	0.5482	0.4067	0.3418
35-39	1.3226	1.0446	0.7617	0.6460	1.1364	0.8824	0.6278	0.5242
40-44	2.1134	1.6576	1.1671	0.9820	1.8515	1.4302	0.9776	0.8112
45-49	3.0659	2.4037	1.6583	1.3935	2.7264	2.1124	1.4197	1.1763
50-54	4.1250	3.2575	2.2072	1.8666	3.7058	2.9004	1.9314	1.6145
55-59	5.3119	4.2342	2.8387	2.4201	4.8009	3.7995	2.5061	2.1173
60-64	6.5206	5.2642	3.4893	3.0055	5.9325	4.7623	3.1159	2.6649
65-69	7.1082	5.8323	3.8391	3.3584	6.5106	5.3104	3.4437	2.9949

Life Insurance Company of Alabama
Cancer Benefit Policy
Policy Form HC882012
Monthly Issue Age Premium Rates per 1,000

Primay Insured Only

	Guaranteed Issue or "EZ" Underwriting				Full Underwriting			
	Tobacco		Non-Tobacco		Tobacco		Non-Tobacco	
Issue Age	Male	Female	Male	Female	Male	Female	Male	Female
18-24	0.2220	0.2746	0.1884	0.2476	0.1527	0.2000	0.1225	0.1756
25-29	0.3051	0.3896	0.2361	0.3353	0.2283	0.3041	0.1667	0.2552
30-34	0.4587	0.5727	0.3184	0.4650	0.3623	0.4635	0.2367	0.3678
35-39	0.7368	0.8493	0.4550	0.6413	0.6059	0.7063	0.3536	0.5202
40-44	1.2376	1.2711	0.6900	0.8793	1.0420	1.0740	0.5507	0.7197
45-49	2.0541	1.8494	1.0444	1.1320	1.7859	1.5976	0.8591	0.9374
50-54	3.2645	2.5815	1.5381	1.3894	2.9076	2.2766	1.3099	1.1708
55-59	4.8779	3.4700	2.1639	1.6875	4.3906	3.0897	1.8790	1.4363
60-64	6.5923	4.3328	2.7908	1.9595	6.0057	3.8961	2.4668	1.6923
65-69	7.2898	4.4827	3.0901	2.0086	6.6831	4.0529	2.7456	1.7320

Primary Insured + Spouse

	Guaranteed Issue or "EZ" Underwriting				Full Underwriting			
	Tobacco		Non-Tobacco		Tobacco		Non-Tobacco	
Issue Age	Male	Female	Male	Female	Male	Female	Male	Female
18-24	0.3207	0.3467	0.2734	0.3026	0.2391	0.2629	0.1969	0.2234
25-29	0.4603	0.5018	0.3644	0.4134	0.3659	0.4037	0.2804	0.3246
30-34	0.7015	0.7575	0.5081	0.5806	0.5793	0.6303	0.4055	0.4711
35-39	1.1142	1.1703	0.7286	0.8225	0.9435	0.9971	0.5987	0.6816
40-44	1.8163	1.8358	1.0740	1.1676	1.5801	1.5946	0.8938	0.9784
45-49	2.9132	2.8158	1.5483	1.5934	2.5844	2.4887	1.3205	1.3601
50-54	4.4897	4.1512	2.1694	2.0964	4.0437	3.7341	1.8935	1.8255
55-59	6.5409	5.8361	2.9363	2.7001	5.9401	5.2853	2.5946	2.3751
60-64	8.6814	7.5578	3.7045	3.2872	7.9550	6.8963	3.3148	2.9268
65-69	9.4591	8.0603	4.0130	3.4754	8.7114	7.3851	3.6082	3.1042

Primary Insured + Child(ren)

	Guaranteed Issue or "EZ" Underwriting				Full Underwriting			
	Tobacco		Non-Tobacco		Tobacco		Non-Tobacco	
Issue Age	Male	Female	Male	Female	Male	Female	Male	Female
18-24	0.2329	0.2851	0.1992	0.2582	0.1603	0.2076	0.1300	0.1833
25-29	0.3165	0.4005	0.2481	0.3467	0.2368	0.3126	0.1751	0.2639
30-34	0.4703	0.5830	0.3310	0.4760	0.3717	0.4730	0.2457	0.3765
35-39	0.7479	0.8592	0.4677	0.6525	0.6156	0.7162	0.3635	0.5296
40-44	1.2475	1.2817	0.7024	0.8881	1.0503	1.0826	0.5603	0.7284
45-49	2.0623	1.8568	1.0548	1.1415	1.7966	1.6072	0.8677	0.9452
50-54	3.2710	2.5918	1.5457	1.3963	2.9192	2.2857	1.3178	1.1802
55-59	4.8860	3.4758	2.1711	1.6942	4.3994	3.0959	1.8865	1.4449
60-64	6.6033	4.3400	2.8001	1.9660	6.0080	3.9039	2.4767	1.6991
65-69	7.3044	4.4917	3.0953	2.0126	6.6917	4.0578	2.7468	1.7355

Family

	Guaranteed Issue or "EZ" Underwriting				Full Underwriting			
	Tobacco		Non-Tobacco		Tobacco		Non-Tobacco	
Issue Age	Male	Female	Male	Female	Male	Female	Male	Female
18-24	0.3310	0.3565	0.2836	0.3129	0.2487	0.2718	0.2060	0.2324
25-29	0.4712	0.5129	0.3761	0.4249	0.3769	0.4142	0.2905	0.3349
30-34	0.7142	0.7699	0.5204	0.5930	0.5909	0.6416	0.4168	0.4816
35-39	1.1276	1.1820	0.7420	0.8348	0.9566	1.0071	0.6106	0.6935
40-44	1.8308	1.8468	1.0866	1.1793	1.5896	1.6042	0.9063	0.9894
45-49	2.9277	2.8252	1.5607	1.6030	2.5948	2.4987	1.3310	1.3710
50-54	4.5046	4.1595	2.1802	2.1048	4.0598	3.7416	1.9049	1.8347
55-59	6.5518	5.8458	2.9461	2.7091	5.9520	5.2959	2.6050	2.3846
60-64	8.6958	7.5675	3.7119	3.2938	7.9591	6.9101	3.3215	2.9327
65-69	9.4733	8.0670	4.0197	3.4812	8.7190	7.3998	3.6154	3.1104

Life Insurance Company of Alabama
Health Screening Rider

Exhibit B - Monthly Gross Premium Rates Per Unit

Diagnostic Rider - Form HH89W2012

	$25 Wellness Benefit			
	Issue Age			
Coverage	18-39	40-54	55-64	65+
Named Insured	1.25	1.65	1.90	2.20
Named Insured & Spouse	2.40	3.05	3.65	4.10
One Parent Family	1.50	1.90	2.30	2.60
Two Parent Family	2.65	3.40	4.05	4.55

* One Rate premiums only available in the worksite and require a minimum of 10 insured's purchasing coverage

Factor Adjustments:

1) Worsksite Market	0.90
2) Direct Market	1.00

Life Insurance Company of Alabama
Health Screening Rider

Exhibit B - Monthly Gross Premium Rates Per Unit

Diagnostic Rider - Form HC88W2012

	$25 Wellness Benefit			
	Issue Age			
Coverage	18-39	40-54	55-64	65+
Named Insured	1.40	1.80	2.15	2.45
Named Insured & Spouse	2.70	3.40	4.05	4.55
One Parent Family	1.70	2.15	2.55	2.90
Two Parent Family	2.95	3.75	4.50	5.05

* One Rate premiums only available in the worksite and require a minimum of 10 insured's purchasing coverage

Factor Adjustments:

1) Worsksite Market	0.90
2) Direct Market	1.00

SERFF Tracking #:	*HESS-128670082*	***State Tracking #:***	***Company Tracking #:*** *AMHLOACIAR*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved	12/17/2012
Comments:			
Attachment(s):			
Flesch Score.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Application	Approved	12/17/2012
Comments:			
Attachment(s):			
MP A&H 2012.pdf MP LIFE 2012.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Outline of Coverage	Approved	12/17/2012
Comments:			
Attachment(s):			
OCHH892012 AR.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Authorization Letter	Approved	12/17/2012
Comments:			
Attachment(s):			
Authorization for Toni - 2012.pdf			

READABILITY COMPLIANCE CERTIFICATION

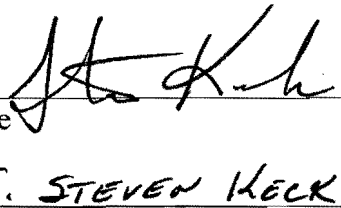
Life Insurance Company of Alabama
302 Broad Street
Gadsden, Alabama 35901

I hereby certify that the Flesch Reading Ease Test Score of the listed forms are as follows:

Form Number(s)	Type and/or Title of Form(s)	Flesch Score
HH892012	**Critical Illness Benefit Policy**	**46.1**
HC882012	**Cancer Benefit Policy**	**45.0**
HH89W2012	**Health Screening Rider**	**54.5**
HC88W2012	**Health Screening Rider**	**54.5**
MP AH 2012	**Application**	**42.0**
MP LIFE 2012	**Application**	**44.1**
OCHH892012	**Outline of Coverage**	**43.4**
OCHC882012	**Outline of Coverage**	**46.5**

The type size of the text is at least 10-pointed leaded.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department of this state.



Signature

J. STEVEN KECK

Name

CHIEF OPERATING OFFICER

Officer Title

APPLICATION FOR A&H INSURANCE - PART 1

Please Use Dark Ink Suitable for Photocopying.

Life Insurance Company of Alabama

P. O. Box 349 • Gadsden, Alabama 35902

Proposed Insured

1. NAME (Last, Suffix, First, M.I.) _____

BIRTHDATE ☐☐/☐☐/☐☐☐☐ STATE OF BIRTH ☐☐ SSN# ☐☐☐-☐☐-☐☐☐☐

If eligible for Medicare, deliver appropriate Medicare disclosure found on page 11

HEIGHT ☐'☐☐" WEIGHT ☐☐☐ MALE ☐ FEMALE ☐ _____ ☐☐ ISSUE STATE

Driver License #

ADDRESS _____

CITY _____ STATE ☐☐ ZIP ☐☐☐☐☐

EMAIL _____

PHONE ☐☐☐-☐☐☐-☐☐☐☐ PHONE #2 ☐☐☐-☐☐☐-☐☐☐☐

INSURED'S EMPLOYER _____ EMPLOYMENT DATE ☐☐/☐☐/☐☐☐☐

OCCUPATION _____

Describe and give exact duties

2. Has any person proposed for insurance used tobacco in any form within the last 24 months? Yes ☐ No ☐

3. Are all persons proposed for insurance citizens of U.S.A? Yes ☐ No ☐

Dependents

4. NAME	DATE OF BIRTH Mo.	Day	Yr.	STATE OF BIRTH	GENDER (M / F)	SOCIAL SECURITY NUMBER	HEIGHT (FT. IN.)	(LBS.) WEIGHT
PROPOSED LEGAL SPOUSE								
PROPOSED LEGAL CHILDREN								

If additional children, use a separate sheet of paper. Signed and dated by the Insured.

5. Do you have a current Medicaid eligibility card or other state sponsored insurance program? ☐ Yes ☐ No

DETAILS OF questions 2 - 20 answered "yes": Include question #, names and addresses of physicians and individuals to whom the history pertains in PART 8.

6. Has any person listed above and proposed for coverage ever tested positive for exposure to Human Immunodeficiency Virus (HIV) infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by Human Immunodeficiency Virus (HIV) infection or other sickness or condition derived from such infection?

☐ Yes ☐ No

HOME OFFICE USE

Payment Information

7. PAYMENT MODE *(Monthly Direct Bill Not Available)*

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

☐ Bank Draft ☐ Payroll Deduction ☐ Direct Bill

☐ Payment with app $_____ ☐ Draft first payment

Additional details_____

BILLING ADDRESS INFORMATION

☐ Proposed Insured's address ☐ Primary Owner's address

☐ Other Premium Payor's / Alternate billing address *(details below)*

Name _____

Street _____

City _____ *State*____ *ZIP*_____

☐ *Special arrangements* _____

If Bank Draft Payment is chosen, complete Authorization to Honor Checks on page 12

Existing Insurance

8. EXISTING INSURANCE

Will the policy(s) applied for replace any insurance in force on any proposed covered person? Yes ☐ No ☐

If YES, complete and submit attached replacement form (found on page 9) along with this application and list all in force insurance coverage(s) below.

Insured's Name	Company	Owner	Replacement	Amount	Year Issued
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		

Beneficiary Designation

9.	Name and Address	Relationship		%
Insured			Primary	
Insured			Contingent	
Spouse			Primary	
Spouse			Contingent	

If additional beneficiaries, use a separate sheet of paper. Signed and dated by the Insured.

APPLICATION FOR A&H INSURANCE - PART 3

CANCER INDEMNITY *☐ Advantage *☐ Choice
Health & Wellness Benefit ☐ $100 ☐ $50
Daily Room ☐ $300 ☐ $200 ☐$100
Rad. & Chemo. ☐ Option A ☐ Option B ☐ Option C
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
*Answer Question 11 $_____

First Occurrence Rider ☐ 2 Units ☐ 1 Unit / ☐ Level ☐ Building
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
$_____

Intensive Care Benefit: I75 ☐ *Rider ☐ ✤Stand Alone
☐ $300 ☐ $450 ☐ $600 ☐ Other _____ $_____
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
*Answer Question 12 ✤Answer Questions 12, 15 & 16

Specified Disease Benefit Rider* $_____
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
*Answer Question 13 Cancer Indemnity Total$_____

INPATIENT + OUTPATIENT HOSPITAL INDEMNITY PLAN*
☐ Payroll Only Plan (HI67) ☐ Individual Non-Payroll Plan (HI68)
☐ Individual ☐ One Parent ☐ Emp. & Spouse ☐ Two Parent
Daily Hospital Benefit $_____
OPTIONAL BENEFITS: Initial Conf. $_____
Surg. Benefit $_____ Emer. Acc. $_____
Outpat. Sickness $_____ Other $_____
Major Injury (Broken Bones) Units ☐ 1 ☐ 2 ☐ 3
*Record Height & Weight in Part 1 & Answer Questions 10(a) & 15 - 20
$_____

Intensive Care Benefit: I63*
☐ $300 ☐ $450 ☐ $600 ☐ Other _____ $_____
☐ Individual ☐ One Parent ☐ Two Parent
*Answer Question 12
Inpatient + Outpatient Plan Total $_____

VOLUNTARY GROUP DENTAL INSURANCE
☐ Plan I ☐ Plan II
☐ Children Orthodontic Care Rider [☐ Vision & Hearing Rider]
☐ Employee ☐ Employee/Children ☐ Family
*Answer Question 14 Dental Total $_____

CRITICAL ILLNESS
☐ Cancer Benefits** $_____ FACE AMOUNT
☐ Heart & Stroke Benefits* $_____ FACE AMOUNT
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
$_____
**Answer Questions 15 - 19
*Record Height & Weight in Part 1 Answer Questions 15 - 19

Intensive Care Benefit: I75 ☐ *Rider ☐ ✤Stand Alone
☐ $300 ☐ $450 ☐ $600 ☐ Other _____ $_____
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
*Answer Question 12 ✤Answer Questions 12, 15 & 16

Critical Illness Total $_____

ACCIDENT INCOME PROVIDER * ☐ $3000 ☐ $1500
SENIOR ACC. INCOME PROVIDER * ☐ $3000 ☐ $1500
☐ Individual ☐ One Parent ☐ Two Parent
*Answer Question 10(a) Accident Income Provider Total $_____

ACCIDENT DISABILITY PLAN * (90 Day Employment Required)
Pre-Packaged Plan ☐ 400 ☐ 600 ☐ 800 ☐ 1000 ☐ 1200
Applicant's Gross Monthly Income $_____
☐ 24 Hour Coverage ☐ Off-The-Job Only
☐ Emp ☐ Emp/Sp ☐ Emp/Ch ☐ Emp/Fam $_____
*Answer Question 10(a)

✦**BUILD A PLAN** Monthly Income $_____ FACE AMOUNT
Applicant's Gross Monthly Income $_____
☐ 24 Hour Coverage ☐ Off-The-Job Only
Benefit Period ☐ 6 months ☐ 1 Year
Accident Elimination Period ☐ 0 ☐ 7 Days
☐ Emp ☐ Emp/Sp ☐ Emp/Ch ☐ Emp/Fam $_____
*Answer Question 10(a)
✦Does not apply to Packaged Accident Disability Plans

*Sickness Disability Rider Mo. Inc. $_____ FACE AMOUNT
Benefit Period ☐ 6 month ☐ 1 year
Elimination ☐ 7 or ☐ 14 days ☐ 30 days $_____
*Record Height & Weight in Part 1 & Answer Questions 15 - 19

SICKNESS & ACCIDENT DISABILITY INCOME PLAN*
☐ Standard ☐ Preferred (90 Day Employment Required)
Monthly Disability Benefit $ _____ FACE AMOUNT
Applicant's Gross Monthly Income $ _____
Benefit Period ☐ 3 months ☐ 6 months ☐ 1 Year ☐ 2 Years
Accident Elimination Period ☐ 0 ☐ 7 ☐ 14 Days
Sickness Elimination Period ☐ 7 ☐ 14 ☐ 30 ☐ 60 ☐ 90 ☐ 180 Days
*Record Height & Weight in Part 1 & Answer Questions 10(a) and 15 - 20
$_____

Optional Benefits for Sickness &/or Accident Disability Plan:
Level of coverage (i.e. Emp, Emp/Sp, Emp/Ch, Emp/Fam) for optional benefits is determined by the level of coverage selected for base policy.

☐ ✦Initial Hospital Confinement Benefit $1000 $_____

✦Injury Treatment Benefit $_____
☐ $100 ☐ $150 ☐ $200 ☐ $250 ☐ $300

☐ ✦Health Screening Benefit $_____

✦AD&D Benefit $_____
☐ $10k ☐ $15k ☐ $20k ☐ $25k ☐ $30k

☐ Supplemental Injury Benefit $_____

☐ **Specific Loss Rider (Broken Bone)** $_____

Intensive Care Benefit* **I75** ☐ ✤Stand Alone $_____
☐ $300 ☐ $450 ☐ $600 ☐ Other _____
*Answer Question 12 ✤Answer Questions 12, 15 & 16
✦Does not apply to Pre-Packaged Accident Disability Plans
Sickness &/or Accident Disability Income Plan Total $_____

APPLICATION FOR A&H INSURANCE - PART 4

DETAILS OF questions 2 - 20 answered "yes": Include question #, names and addresses of physicians and individuals to whom the history pertains in PART 8.	PROPOSED INSURED		SPOUSE		CHILDREN	
	Yes	No	Yes	No	Yes	No
10a. Is any proposed insured currently in the hospital or receiving disability payments?	☐	☐	☐	☐	☐	☐
Answer 6, 10(a), (b) & (c) when offering a plan approved for E-Z Underwriting						
(b) Is proposed primary insured working at least 30 hours per week?	☐	☐				
(c) In the past 5 years has any proposed insured been treated by a licensed member of the medical profession for a heart attack, stroke, internal cancer, melanoma, disease or disorder of the lungs or hepatitis?	☐	☐				
11. CANCER ADVANTAGE & CHOICE	Yes	No	Yes	No	Yes	No
(a) Has any person proposed for coverage under this Policy within the last 24 months, had any elevated or rising PSA or CEA test or abnormal mammogram, pap smear, radiological exam (e.g. X-Ray, MRI, CAT Scan, sonogram, ultrasound, echo tests, etc.), biopsy or scope procedure (e.g. colonoscopy, endoscopy, etc.) or are awaiting further tests or test results?	☐	☐	☐	☐	☐	☐
(b) Has any person proposed for coverage under this Policy within the last five years, been diagnosed as having or been treated for any cancer, including skin cancer, Hodgkin's Disease and Leukemia, in any form?	☐	☐	☐	☐	☐	☐
(c) Has any person proposed for coverage under this Policy been diagnosed, as having or been treated for any cancer, including skin cancer, Hodgkin's Disease and Leukemia, in any form over five years ago?	☐	☐	☐	☐	☐	☐
If yes to question 11a or b any person(s) so designated will not be covered under the policy. If yes to question 11c, you are eligible for a policy that provides Option C Radiation & Chemotherapy Benefits and $100 per day Daily Room Benefit for the treatment of cancer. No additional amounts will be issued.						
12. INTENSIVE CARE: Has any proposed insured ever been diagnosed or treated for heart disease, heart attack, any heart condition, heart trouble or any abnormality of the heart?	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐
(a) Are you, your spouse, your fiancé, your companion or any other person to be covered by this policy/rider currently pregnant or taking fertility drugs?	☐	☐	☐	☐	☐	☐
If yes to question (a), we will issue an individual policy / rider on the adult male family member only.						
Answer Questions 12, 15, and 16 for Intensive Care Stand Alone Policy						
13. SPECIFIED DISEASE: Has any person proposed for coverage under this Policy ever had treatment or diagnosis of: • Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) • Botulism • Bubonic Plague • Cerebral Palsy • Cholera • Cystic Fibrosis • Diphtheria • Encephalitis (including encephalitis contracted from West Nile virus) • Huntington's Chorea • Lyme Disease • Malaria • Menningitis (Bacterial) • Multiple Sclerosis • Muscular Dystrophy • Myasthenia Gravis • Necrotizing Fasciitis • Osteomyelitis • Polio • Rabies • Reye's Syndrome • Rheumatic Fever • Rocky Mountain Spotted Fever • Scleroderma • Sickle Cell Anemia • Smallpox • Systemic Lupus • Tetanus • Toxic Shock Syndrome • Tuberculosis • Tularemia • Typhoid Fever • Variant Creutzfeldt-Jakob Disease (Mad Cow Disease) • Yellow Fever?	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐
14. DENTAL:	Yes	No	Yes	No	Yes	No
(a) Are all children listed legal dependents of the Proposed Insured or Spouse?	☐	☐				
(b) Is their permanent residence the residence of the Proposed Insured? *If "No", please explain in details section.*	☐	☐				
(c) Are any children listed a full-time student? *If "Yes", please explain in details section.*	☐	☐				
(d) Are all eligible family members listed above? *If "No", please explain in details section.*	☐	☐				
(e) Are you or any person to be insured covered by any other dental insurance policy or certificate? *If "Yes", please give name of the company, Policy Number, Covered Person(s) name in details section.*	☐	☐	☐	☐	☐	☐
(f) Will this policy replace existing coverage? *If yes, when will existing coverage terminate?*	☐	☐	☐	☐	☐	☐
(g) Is proposed primary insured working at least 30 hours per week?	☐	☐				

APPLICATION FOR A&H INSURANCE - PART 5

DETAILS OF questions 2 - 20 answered "yes": Include question #, names and addresses of physicians and individuals to whom the history pertains in PART 8.	PROPOSED INSURED		SPOUSE		CHILDREN	
15. HAS ANY PERSON proposed for insurance in Part 1:	Yes	No	Yes	No	Yes	No
(a) Used marijuana, narcotic, hallucinogenic or habit forming drugs not prescribed by a physician?	☐	☐	☐	☐	☐	☐
(b) Had any motor vehicle moving violations or accidents within the last two years?	☐	☐	☐	☐	☐	☐
(c) Been arrested for any reason other than moving traffic violations?	☐	☐	☐	☐	☐	☐
(d) Ever had an application for insurance or reinstatement of insurance declined, postponed, rated up or modified?	☐	☐	☐	☐	☐	☐
16. IN THE LAST 10 YEARS, HAS ANY PERSON proposed for insurance in Part 1 ever been treated by a licensed member of the medical profession for:	Yes	No	Yes	No	Yes	No
(a) Heart attack, chest pain, heart murmur, high blood pressure or any other disease of the heart, blood or blood vessels?	☐	☐	☐	☐	☐	☐
(b) Peptic ulcer, Ulcerative Colitis, Crohn's disease or any disease of the esophagus, stomach, intestines, pancreas or liver?	☐	☐	☐	☐	☐	☐
(c) Emphysema, bronchitis, asthma, Chronic Obstructive Pulmonary Disease (COPD) or any disease of the lungs or respiratory system?	☐	☐	☐	☐	☐	☐
(d) Hepatitis, diabetes, albumin, pus, blood or sugar in urine, venereal disease or any other disease of the kidneys, bladder, gland, reproductive organs or connective tissue disorder?	☐	☐	☐	☐	☐	☐
(e) Stroke, transient ischemic attack (TIA), severe headaches, fainting spells, epilepsy, paralysis, nervousness, mental disorder or any other disease of the brain, nervous system or been treated for a back or neck condition?	☐	☐	☐	☐	☐	☐
(f) Any disease or disorder of the eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐
(g) Alcohol or drug abuse?	☐	☐	☐	☐	☐	☐
(h) Any cancer or tumor including cancer of the bone marrow, blood, lymph nodes, carcinoma-in-situ, skin cancer or melanoma?	☐	☐	☐	☐	☐	☐
(i) Are you, your spouse, your fiancé, your companion or any other person to be covered by this policy/rider currently pregnant or taking fertility drugs?	☐	☐	☐	☐	☐	☐
(j) Any abnormality, deformity, disease, illness, injury or disorder not mentioned above?	☐	☐	☐	☐	☐	☐
17. OTHER THAN INDICATED ABOVE, has any person proposed for insurance in Part 1:	Yes	No	Yes	No	Yes	No
(a) Ever applied for or received a pension or disability benefit?	☐	☐	☐	☐	☐	☐
(b) Been hospitalized in the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(c) Consulted a physician during the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(d) Had a change of weight in the past year?	☐	☐	☐	☐	☐	☐
(e) Is proposed primary insured working at least 30 hours per week?	☐	☐	☐	☐	☐	☐
(f) Had an immediate family member (Father, Mother, Brothers or Sisters) with a history of diabetes, mental, nervous, heart or circulatory disorder, tuberculosis, cancer, high blood pressure, kidney disease or suicide? If so, include age(s) at diagnosis, condition, relationship, age(s) if living, age(s) at death and cause of death.	☐	☐	☐	☐	☐	☐
18. IN THE LAST 24 MONTHS, has any person proposed for insurance in Part 1 been under observation or treatment of a physician or had or been advised to have any diagnostic test, procedure, screening or surgery or awaiting test results? If yes, please provide details including date(s), reason(s) and result(s).	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐
19. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? If yes please indicate if Retired or active: list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in PART 8.	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐
20. HAS ANY PERSON proposed for insurance in Part 1:	Yes	No	Yes	No	Yes	No
(a) Flown other than as a fare-paying passenger within the last two years or considering such flying in the next two (2) years? If yes, complete Aviation Questionnaire.	☐	☐	☐	☐	☐	☐
(b) Any past, present or expected (in the next two (2) years) activity in racing, skin or sky diving, bungee jumping, base jumping, parasailing, rock climbing, hang gliding or ultra-light flying? If yes, complete Hazardous Sports Questionnaire.	☐	☐	☐	☐	☐	☐

APPLICATION FOR A&H INSURANCE - PART 6

Please provide name of doctor, practitioner, or health care facility who can provide the most complete and up-to-date information concerning any health condition listed on Part 4 of this application for any Proposed Insured.

Physician Information

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION I hereby authorize the above person(s) or entity(s) listed in above and MIB, Inc. and any prescription drug or pharmacy organization(s) to provide **Life Insurance Company of Alabama,** or its reinsurers, or to **Lab One/Exam One** on the behalf of Life Insurance Company of Alabama, information, data, or records concerning advice, care, treatment or health history provided to the person(s) named above, including, but not limited to, notes, reports, test results, x-rays, documents related to any mental conditions, cost of medical services, prognosis, physician notes of patient interviews, patient notes, pharmacy records or other data and including the full and complete clinical records, hospital charts, examination records and medical history I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol program; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition; information relating to HIV testing, HIV status, or AIDS. I understand that such information may be subject to special protections pursuant to law and that by signing this authorization, I authorize the person(s) or entity(s) listed to disclose records containing such information. Please list any special instructions. I authorize Life Insurance Company of Alabama, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.. I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at: *Life Insurance Company of Alabama, Attn: Privacy Official, PO Box 349, Gadsden, AL 35902*. I understand that the revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when my insurance coverage ends (twenty-four (24) months from the date shown below in Kentucky and Oklahoma, thirty (30) months from the date shown below in Georgia and North Carolina), if not revoked before such date. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that this authorization is needed for the purpose of gathering information for making eligibility, underwriting and risk rating determinations.

BY MY SIGNATURE(s) below I do attest that the statements and answers in all parts of this application are complete and true and will be the basis for any insurance issued. If I am eligible for Medicare, I have received the Important Notice to Persons on Medicare.

As normal procedure, the Home Office Underwriting Department may contact you by telephone to verify pertinent information contained in your application.

Arkansas Only:
Is any person to be covered for specified disease also covered by any Title XIX program Medicaid or similar coverage.
☐ Yes ☐ No

Signed at_____
City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Payor if other than Proposed Insured

AGREEMENT Terms used In this Agreement:
"You" and "Your" mean the Proposed Insured and the Applicant, if other than the Proposed Insured. "We", "us" and "our" mean the Life Insurance Company of Alabama. It is understood and agreed by you that:
(a) Any policy issued as a result of this application shall constitute a single and entire contract of insurance. Only the President, a Vice President, the Secretary or an Assistant Secretary of the Company may make a contract on its behalf. No waiver or modification of a contract provision or any of the Company's rights or requirements shall be binding upon the Company unless it is in writing signed by one of such officers. NEITHER THE AGENT WHOSE SIGNATURE APPEARS BELOW, NOR ANY OTHER AGENT OR BROKER, NOR ANY MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS, PASS UPON INSURABILITY, MAKE OR MODIFY CONTRACTS OR WAIVE ANY OF THE COMPANY'S RIGHTS OR REQUIREMENTS.
(b) To the best of your knowledge and belief all of the statements and answers on this application are true, complete and correctly stated. These statements and answers are offered to us as the basis for any policy issued on this application.
(c) Unless the policy becomes effective as specified in the Temporary Insurance Agreement attached to this application, we will incur no liability until (1) any policy applied for has been delivered to and accepted by you and (2) the first premium is paid. When you accept the policy, the state of health of the Proposed Insured and/or Applicant or any other factor affecting insurability must be the same as set forth in the application.
(d) Acceptance of the policy issued based on this application will be an acceptance of its terms and ratifications of any changes specified in the section marked "Home Office Endorsements". Any change in plan or amount of insurance, premium, classification or added benefits must be agreed to in writing.
(e) No Agent Broker or Medical Examiner can accept risks or waive any of our requirements, nor can the Agent, Broker or Medical Examiner make or alter contracts. Notice to or knowledge imputed to any Agent, Broker, Medical Examiner will not be notice to or knowledge of us unless it is set out in writing in this application.
(f) Any life insurance issued as a result of this application shall be owned by the applicant or by person(s) who receive ownership from the applicant.

Disclosures

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

Arkansas, Louisiana, Mississippi, North Carolina, South Carolina: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be subject to fines and confinement in prison.

Florida: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Georgia, Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to any insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial or insurance benefits.

I represent that copies of all sales materials and required disclosures, including Medicare disclosure have been left with the Proposed Insured.

Writing Agent

X _____
Agent LICOA Agent's No.

_____
Agent LICOA Agent's No.

_____
Agent LICOA Agent's No.

_____
Agent LICOA Agent's No.

AGENT'S STATEMENT: To the best of your knowledge does this insurance replace any existing insurance? ☐ Yes ☐ No
If Yes, give name of company and policy number.

APPLICATION FOR A&H INSURANCE - PART 8

DETAILS OF questions 2 - 20 answered "yes": Include question #, names and addresses of physicians and individuals to who history pertains.

If additional details, use a separate sheet of paper. Signed and dated by the Insured.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Life Insurance Company of Alabama. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X _____
Agent Signature LICOA Agent's No.

This Notice is to be detached, read, and retained by the Proposed Insured

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

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Accident and Disability Coverage

Important Notice to Persons on Medicare This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays: hospital or medical expenses up to the maximum stated in the policy.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include: · hospitalization · physician services · outpatient prescription drugs if you are enrolled in Medicare Part D · other approved items and services

Cut along dotted line.

Cancer and/or Heart Coverage

Important Notice to Persons on Medicare This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include: · hospitalization · physician services · hospice · outpatient prescription drugs if you are enrolled in Medicare Part D · other approved items and services

Cut along dotted line.

Intensive Care Coverage

Important Notice to Persons on Medicare This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when: · any expenses or services covered by the policy are also covered by Medicare; or · it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include: · hospitalization · physician services · hospice care · outpatient prescription drugs if you are enrolled in Medicare Part D · other approved items & services

Cut along dotted line.

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ **For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program SHIP.**

Cut along dotted line.

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

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✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ **For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program SHIP.**

Cut along dotted line.

AUTHORIZATION TO HONOR CHECKS DRAWN BY AND PAYABLE TO THE LIFE INSURANCE COMPANY OF ALABAMA, GADSDEN, ALABAMA

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks drawn by and payable to the order of the Life Insurance Company of Alabama, Gadsden, Alabama provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of The Life Insurance Company of Alabama to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Name of financial institution_____ City_____ State_____

I would like the payment withdrawn on the_____ (select the 1st through the 28th) day of the month.

Checking account no. _____ OR Savings account no._____

Signature as it appears on bank records (do not print) **X**_____

BILLING DATA AND PAYROLL DEDUCTION AUTHORIZATION

PART I - REQUIRED ON EACH SALARY SAVINGS POLICY (*PLEASE PRINT OR TYPE*)

EFFECTIVE DATE	NAME OF EMPLOYEE	SOCIAL SECURITY NO.
DEPT. NO.	NAME OF EMPLOYER	MONTHLY PREMIUM
EMP. NO.	INDICATE TYPE OF COVERAGE	WEEKLY PREMIUM

PART II - REQUIRED IF A PREMIUM IS TO BE PAID BY EMPLOYEE

I hereby request and authorize you to deduct the premium from my wage and to transmit it to Life Insurance Company of Alabama (LICOA). These deductions are to cover the premiums on the insurance policy I have applied for if the policy is issued by LICOA.

I acknowledge that this authorization is being signed at the same time I am applying for insurance coverage with LICOA, but IN NO EVENT WILL ANY INSURANCE BE IN FORCE UNTIL THE EFFECTIVE DATE OF ANY POLICY WHICH MAY BE ISSUED BY LICOA. This authorization also allows you to increase my deduction for any premium increases on the policy which may be made by LICOA.

_____ **X** _____

DATE SIGNATURE OF EMPLOYEE

Cut along dotted line.

This Notice is to be detached, read, and retained by the Proposed Insured

FAIR CREDIT REPORT ACT NOTICE

Under Public Law 91-508, we are required to inform persons proposed for insurance that, as part of our regular underwriting procedure, an investigative consumer report may be obtained, which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with your friends, neighbors, and associates. Upon written request to the Manager-Individual Policy Department at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, Alabama 35902, further information on the nature and scope of the report will be provided. **You or any person authorized to act on your behalf are entitled to receive a copy of this Authorization Form.**

To: The Bank named on the reverse side.

The Life Insurance Company of Alabama agrees:

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
(2) In the event that any such check, draft or order shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

THE LIFE INSURANCE COMPANY OF ALABAMA, Gadsden, Alabama

Clarence W. Daugette Jr.
President

Authorized in resolution adopted by the Executive Board of
The Life Insurance Company of Alabama on April 29, 1974

MEDICAL INFORMATION BUREAU, INC. (MIB), NOTICE Information regarding your insurability will be treated as confidential. We or our Reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. We or our reinsurers may release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com. The purpose of the bureau is to protect its members and their policyholders from the extra expense created by those who omit or conceal information relevant to their insurability. Information furnished by the Bureau may serve to alert the company to a need for further investigation but under Bureau rules cannot be used either wholly or partly as the basis for increasing the charge for or denying the issuance of insurance. Information in the Bureau gives no indication regarding the action taken on an application (i.e., whether accepted standard, accepted with increased premium, or declined).

APPLICATION FOR LIFE INSURANCE - PART 1

Please Use Dark Ink Suitable for Photocopying.

Life Insurance Company of Alabama

P. O. Box 349 • Gadsden, Alabama 35902

Proposed Insured

1. NAME (Last, Suffix, First, M.I.) _____

BIRTHDATE ___/___/___ STATE OF BIRTH ___ SSN# ___-___-___

HEIGHT ___' ___" WEIGHT ___ MALE ☐ FEMALE ☐ _____ Driver License # ___ ISSUE STATE

ADDRESS _____

CITY _____ STATE ___ ZIP ___

EMAIL _____

PHONE ___-___-___ PHONE #2 ___-___-___

INSURED'S EMPLOYER _____ EMPLOYMENT DATE ___/___/___

OCCUPATION _____
Describe and give exact duties

1a. Have you used tobacco in any form within the last 24 months? Yes ☐ No ☐ **1b. Citizen of U.S.A?** Yes ☐ No ☐

Coverage Type

	FACE AMOUNT	MODE PREMIUM
☐ QUICK ISSUE WHOLE LIFE ☐ E-Z Underwriting (Subject to Question 10 and Company Participation requirements)	$ ___,___	$ ___,___.___
☐ QUICK ISSUE LEVEL TERM ☐ 10 yr. ☐ 15 yr. ☐ 20 yr. ☐ 30 yr.	$ ___,___	$ ___,___.___
☐ ACCIDENTAL DEATH BENEFIT	$ ___,___	$ ___,___.___
☐ CHILDRENS TERM ___ UNITS 15 units maximum per family		$ ___,___.___
☐ WAIVER OF PREMIUM		$ ___,___.___
☐ AUTOMATIC PREMIUM LOAN Yes ☐ No ☐ Whole Life Only	TOTAL MODE PREMIUM	$ ___,___.___

Ownership

2. OWNER if other than PROPOSED INSURED

Name _____ *Relationship to Insured* _____

Street _____ Owner's SSN# or TAX ID# ___-___-___

City _____ *State* ____ *ZIP* _____

Proposed Insured becomes owner: ☐ At age of majority ☐ At owner's death ☐ When specified in writing by owner

Children's Term

3. NAME Proposed Legal Children	DATE OF BIRTH Mo.	Day	Yr.	STATE OF BIRTH	GENDER (M / F)	SOCIAL SECURITY NUMBER	HEIGHT (FT. IN.)	(LBS.) WEIGHT

If additional children, use a separate sheet of paper. Signed and dated by the Insured.

APPLICATION FOR LIFE INSURANCE - PART 2

Spouse

1. NAME (Last, Suffix, First, M.I.) _____

BIRTHDATE ☐☐/☐☐/☐☐☐☐ STATE OF BIRTH ☐☐ SSN# ☐☐☐-☐☐-☐☐☐☐

HEIGHT ☐'☐☐" WEIGHT ☐☐☐ MALE ☐ FEMALE ☐ _____ Driver License # ☐☐ ISSUE STATE

ADDRESS _____

CITY _____ STATE ☐☐ ZIP ☐☐☐☐☐

EMAIL _____

PHONE ☐☐☐-☐☐☐-☐☐☐☐ PHONE #2 ☐☐☐-☐☐☐-☐☐☐☐

INSURED'S EMPLOYER _____ EMPLOYMENT DATE ☐☐/☐☐/☐☐☐☐

OCCUPATION _____
Describe and give exact duties

1. Have you used tobacco in any form within the last 24 months? Yes ☐ No ☐ **1a. Citizen of U.S.A?** Yes ☐ No ☐

Coverage Type

	FACE AMOUNT	MODE PREMIUM
☐ QUICK ISSUE WHOLE LIFE	$ ☐☐☐,☐☐☐	$ ☐,☐☐☐.☐☐
☐ QUICK ISSUE LEVEL TERM ☐ 10 yr. ☐ 15 yr. ☐ 20 yr. ☐ 30 yr.	$ ☐☐☐,☐☐☐	$ ☐,☐☐☐.☐☐
☐ ACCIDENTAL DEATH BENEFIT	$ ☐☐☐,☐☐☐	$ ☐,☐☐☐.☐☐
☐ CHILDRENS TERM ☐☐ UNITS 15 units maximum per family		$ ☐,☐☐☐.☐☐
☐ WAIVER OF PREMIUM		$ ☐,☐☐☐.☐☐
☐ AUTOMATIC PREMIUM LOAN Whole Life Only Yes ☐ No ☐	TOTAL MODE PREMIUM	$ ☐,☐☐☐.☐☐

Ownership

2. OWNER if other than PROPOSED INSURED

Name _____

Street _____

City _____ *State*____ *ZIP*_____

Relationship to Insured _____

Owner's SSN# or TAX ID# ☐☐☐-☐☐-☐☐☐☐

Proposed Insured becomes owner: ☐ At age of majority ☐ At owner's death ☐ When specified in writing by owner

Children's Term

3. NAME Proposed Legal Children	DATE OF BIRTH Mo.	Day	Yr.	STATE OF BIRTH	GENDER (M / F)	SOCIAL SECURITY NUMBER	HEIGHT (FT. IN.)	(LBS.) WEIGHT

If additional children, use a separate sheet of paper. Signed and dated by the Insured.

Payment Info. Insured

If Bank Draft Payment is chosen, complete Authorization to Honor Checks

7. PAYMENT MODE *(Monthly Direct Bill Not Available)*

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

☐ Bank Draft ☐ Payroll Deduction ☐ Direct Bill

☐ Payment with app $_____ ☐ Draft first payment

Additional details_____

BILLING ADDRESS INFORMATION

☐ Proposed Insured's address ☐ Primary Owner's address

☐ Other Premium Payor's / Alternate billing address *(details below)*

Name _____

Street _____

City _____ *State*____ *ZIP*_____

☐ *Special arrangements* _____

Payment Info. Spouse

If Bank Draft Payment is chosen, complete Authorization to Honor Checks

7a. PAYMENT MODE *(Monthly Direct Bill Not Available)*

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

☐ Bank Draft ☐ Payroll Deduction ☐ Direct Bill

☐ Payment with app $_____ ☐ Draft first payment

Additional details_____

BILLING ADDRESS INFORMATION

☐ Spouse's address ☐ Primary Owner's address

☐ Other Premium Payor's / Alternate billing address *(details below)*

Name _____

Street _____

City _____ *State*____ *ZIP*_____

☐ *Special arrangements* _____

Existing Insurance

8. EXISTING or APPLIED FOR INSURANCE

Does any Proposed Insured have any existing life insurance or annuity contracts in force or applications pending? Yes ☐ No ☐

If YES, complete and submit attached replacement forms with this application and list all in force and pending life insurance coverage below.

Insured's Name	Company	Owner	Replacement	Life Amount	Accidental Death Benefit	Year Issued
			Yes ☐ No ☐			
			Yes ☐ No ☐			
			Yes ☐ No ☐			
			Yes ☐ No ☐			

Beneficiary Designation

9.	Name and Address	Relationship		%
Insured			Primary	
Insured			Contingent	
Spouse			Primary	
Spouse			Contingent	

If additional beneficiaries, use a separate sheet of paper. Signed and dated by the Insured.

MEDICAL QUESTIONS - PART 4

	PROPOSED INSURED		SPOUSE		CHILDREN TERM RIDER	
	Yes	No	Yes	No	Yes	No
10. IS ANY PERSON PROPOSED FOR INSURANCE currently in the hospital or receiving disability payments; or, in the past 5 years has any proposed insured been treated by a licensed member of the medical profession for a heart attack, stroke, internal cancer, melanoma, disease or disorder of the lungs, hepatitis, tested positive for exposure to Human Immunodeficiency Virus (HIV) infection or been diagnosed as having Aids Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the Human Immunodeficiency Virus (HIV) infection or other sickness or condition derived from such infection?	☐	☐	☐	☐	☐	☐
11. HAS ANY PERSON proposed for insurance in Part 1 and Part 2:						
(a) Used marijuana, narcotic, hallucinogenic or habit forming drugs not prescribed by a physician?	☐	☐	☐	☐	☐	☐
(b) Had any motor vehicle moving violations or accidents within the last two years?	☐	☐	☐	☐	☐	☐
(c) Been arrested for any reason other than moving traffic violations?	☐	☐	☐	☐	☐	☐
(d) Flown other than as a fare-paying passenger within the last two years or considering such flying in the next two (2) years? *(If yes, complete Aviation Questionnaire.)*	☐	☐	☐	☐	☐	☐
(e) Any past, present or expected (in the next two (2) years) activity in racing, skin or sky diving, bungee jumping, base jumping, parasailing, rock climbing, hang gliding or ultra-light flying? *(If yes, complete Hazardous Sports Questionnaire.)*	☐	☐	☐	☐	☐	☐
(f) Ever had an application for insurance or reinstatement of insurance declined, postponed, rated up or modified?	☐	☐	☐	☐	☐	☐
12. IN THE LAST 10 YEARS, HAS ANY PERSON proposed for insurance in Part 1 and Part 2 ever been treated by a licensed member of the medical profession for:						
(a) Heart attack, chest pain, heart murmur, high blood pressure or any other disease of the heart, blood, arteries or blood vessels?	☐	☐	☐	☐	☐	☐
(b) Peptic ulcer, Ulcerative Colitis, Crohn's disease or any disease of the esophagus, stomach, intestines, pancreas or liver?	☐	☐	☐	☐	☐	☐
(c) Emphysema, bronchitis, asthma, Chronic Obstructive Pulmonary Disease (COPD) or any disease of the lungs or respiratory system?	☐	☐	☐	☐	☐	☐
(d) Hepatitis, diabetes, albumin, pus, blood or sugar in urine, venereal disease or any other disease of the kidneys, bladder, gland, reproductive organs or connective tissue disorder?	☐	☐	☐	☐	☐	☐
(e) Stroke, transient ischemic attack (TIA), severe headaches, fainting spells, epilepsy, paralysis, nervousness, mental disorder or any other disease of the brain, nervous system or been treated for a back condition?	☐	☐	☐	☐	☐	☐
(f) Any disease or disorder of the eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐
(g) Tested positive for exposure to Human Immunodeficiency Virus (HIV) infection or been diagnosed as having Aids Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the Human Immunodeficiency Virus (HIV) infection or other sickness or condition derived from such infection?	☐	☐	☐	☐	☐	☐
(h) Alcohol or drug abuse?	☐	☐	☐	☐	☐	☐
(i) Any cancer or tumor including cancer of the bone marrow, blood, lymph nodes, carcinoma-in-situ, skin cancer or melanoma?	☐	☐	☐	☐	☐	☐
(j) Any abnormality, deformity, disease, illness, injury or disorder not mentioned above?	☐	☐	☐	☐	☐	☐
13. OTHER THAN INDICATED ABOVE, has any person proposed for insurance in Part 1 and Part 2:	Yes	No	Yes	No	Yes	No
(a) Ever applied for or received a pension or disability benefit?	☐	☐	☐	☐	☐	☐
(b) Been hospitalized in the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(c) Consulted a physician during the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(d) Had a change of weight in the past year?	☐	☐	☐	☐	☐	☐
(e) Had an immediate family member (Father, Mother, Brothers or Sisters) with a history of diabetes, mental, nervous, heart or circulatory disorder, tuberculosis, cancer, high blood pressure, kidney disease or suicide? In Details section below, include age(s) at diagnosis, condition, relationship, age(s) if living, age(s) at death and cause of death.	☐	☐	☐	☐	☐	☐
14. IN THE LAST 24 MONTHS, has any person proposed for insurance in Part 1 & Part 2 been under observation or treatment of a physician or had or been advised to have any diagnostic test, procedure, screening, surgery or awaiting test results? If yes, please provide details including date(s), reason(s) and result(s).	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐
15. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please indicate if Retired or active: list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the space provided below for "Details".)*	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐

DETAILS OF questions 10 - 15 answered "yes": Include question #, names and addresses of physicians and individuals to whom the history pertains.

If additional details, use a separate sheet of paper. Signed and dated by the Insured.

AGREEMENT **Terms used In this Agreement:**
"You" and "Your" mean the Proposed Insured and the Applicant, if other than the Proposed Insured. "We", "us" and "our" mean the Life Insurance Company of Alabama. It is understood and agreed by you that:
(a) Any policy issued as a result of this application shall constitute a single and entire contract of insurance. Only the President, a Vice President, the Secretary or an Assistant Secretary of the Company may make a contract on its behalf. No waiver or modification of a contract provision or any of the Company's rights or requirements shall be binding upon the Company unless it is in writing signed by one of such officers. NEITHER THE AGENT WHOSE SIGNATURE APPEARS BELOW, NOR ANY OTHER AGENT OR BROKER, NOR ANY MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS, PASS UPON INSURABILITY, MAKE OR MODIFY CONTRACTS OR WAIVE ANY OF THE COMPANY'S RIGHTS OR REQUIREMENTS.
(b) To the best of your knowledge and belief all of the statements and answers on this application are true, complete and correctly stated. These statements and answers are offered to us as the basis for any policy issued on this application.
(c) Unless the policy becomes effective as specified in the Temporary Insurance Agreement attached to this application, we will incur no liability until (1) any policy applied for has been delivered to and accepted by you and (2) the first premium is paid. When you accept the policy, the state of health of the Proposed Insured and/or Applicant or any other factor affecting insurability must be the same as set forth in the application.
(d) Acceptance of the policy issued based on this application will be an acceptance of its terms and ratifications of any changes specified in the section marked "Home Office Endorsements". Any change in plan or amount of insurance, premium, classification or added benefits must be agreed to in writing.
(e) No Agent Broker or Medical Examiner can accept risks or waive any of our requirements, nor can the Agent, Broker or Medical Examiner make or alter contracts. Notice to or knowledge imputed to any Agent, Broker, Medical Examiner will not be notice to or knowledge of us unless it is set out in writing in this application.
(f) Any life insurance issued as a result of this application shall be owned by the applicant or by person(s) who receive ownership from the applicant.

Disclosures

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

Arkansas, Louisiana, Mississippi, North Carolina, South Carolina: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be subject to fines and confinement in prison.

Florida: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Georgia, Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to any insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial or insurance benefits.

I represent that copies of all sales material have been left with the Proposed Insured.

Writing Agent

X _____
Agent LICOA Agent's No.

_____
Agent LICOA Agent's No.

_____
Agent LICOA Agent's No.

_____
Agent LICOA Agent's No.

AGENT'S STATEMENT: To the best of your knowledge does this insurance replace any existing insurance? ☐ Yes ☐ No
If Yes, give name of company and policy number.

AGENT'S STATEMENT: Was the Temporary Life Insurance Agreement left with the owner? ☐ Yes ☐ No

APPLICATION FOR LIFE INSURANCE - PART 6

Please provide name of doctor, practitioner, or health care facility who can provide the most complete and up-to-date information concerning any health condition listed on Part 4 of this application for any Proposed Insured.

Physician Information

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ___ - ___ - ____

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ___ - ___ - ____

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ___ - ___ - ____

AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION I hereby authorize the above person(s) or entity(s) listed in above and MIB, Inc. and any prescription drug or pharmacy organization(s) to provide **Life Insurance Company of Alabama,** or its reinsurers, or to **Lab One/Exam One** on the behalf of Life Insurance Company of Alabama, information, data, or records concerning advice, care, treatment or health history provided to the person(s) named above, including, but not limited to, notes, reports, test results, x-rays, documents related to any mental conditions, cost of medical services, prognosis, physician notes of patient interviews, patient notes, pharmacy records or other data and including the full and complete clinical records, hospital charts, examination records and medical history I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol program; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition; information relating to HIV testing, HIV status, or AIDS. I understand that such information may be subject to special protections pursuant to law and that by signing this authorization. I authorize the person(s) or entity(s) listed to disclose records containing such information. Please list any special instructions. I authorize Life Insurance Company of Alabama, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.. I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at: *Life Insurance Company of Alabama, Attn: Privacy Official, PO Box 349, Gadsden, AL 35902*. I understand that the revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when my insurance coverage ends (twenty-four (24) months from the date shown below in Kentucky and Oklahoma, thirty (30) months from the date shown below in Georgia and North Carolina), if not revoked before such date. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that this authorization is needed for the purpose of gathering information for making eligibility, underwriting and risk rating determinations.

BY THE SIGNATURE(s) below I (we) do attest that the statements and answers in all parts of this application are complete and true and will be the basis for any insurance issued.

As normal procedure, the Home Office Underwriting Department may contact you by telephone to verify pertinent information contained in your application.

HOME OFFICE ENDORSEMENTS:

Signed at_____
City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Owner or Applicant if other than Proposed Insured

X_____
Signature of Spouse

X_____
Signature of Owner or Applicant if other than Spouse

Temporary Life Insurance Agreement and Receipt

A copy of this Agreement is to be left with the owner if all questions are answered 'No' and pre-condition 2 is met. Second copy is sent with the Application.

Do not leave a copy of this Agreement or accept a payment if a question has a 'Yes" answer.

Instead, check "No" on the next page, page 8, and obtain the owner's initials under the acknowledgement section.

Definitions

For purposes of this Temporary Life Insurance Agreement ("Agreement"): "Application" means the Application for Individual Life Insurance from which this Agreement is to be and was physically detached and provided to the owner. "Agent" means the licensed individual who signed this Application as the Agent. "Proposed insured" means the person identified as the proposed life insured, and the person identified as the Spouse life insured, if any, in the Application. "Owner" is identified in the 'Information about the Owner' section of the Application.

Pre-Conditions to Temporary Coverage

Subject to the terms of this Agreement, Life of Alabama agrees to provide the temporary coverage set out in this Agreement if each of the following pre-conditions are met:

1. All questions in this Agreement are answered 'No' and the 'No' answers shown to the questions in this Agreement are truthful.
2. No later than the date of signing this Application, an amount equal to at least a monthly premium for the insurance applied for in the Application was given to the Agent or arrangements have been made for the insurance premium to be payroll deducted through the proposed insured's employer.

If either of the above pre-conditions are not met, no temporary coverage takes effect under this Agreement even if the Agreement was left with the owner.

Temporary Life Insurance Agreement Questions

	Proposed Insured	Spouse
1. Within the past 12 months, has there been either an investigation or treatment, or both, by a physician or medical practitioner for chest pain, heart-related illness, stroke or cancer?	☐ Yes ☐ No	☐ Yes ☐ No
2. Within the past 90 days, been admitted for more than 2 consecutive days to a hospital (other than for childbirth)?	☐ Yes ☐ No	☐ Yes ☐ No
3. Within the past 90 days, has a licensed medical professional recommended a medical test, investigation or surgery, or combination thereof, which was refused to be undertaken or has not yet been undertaken?	☐ Yes ☐ No	☐ Yes ☐ No

Amount given to Agent is $_____ ☐ No amount given to Agent.

Amount of Temporary Coverage

Subject to the terms of this Agreement, if all of the above pre-conditions are met and a proposed insured dies while this Agreement is in effect, Life of Alabama shall pay under this and all other Life of Alabama temporary life insurance agreement(s), to the beneficiary(ies), as shown in the Application, for that proposed insured, the lesser of:

1. The amount of insurance applied for in the Application on the life of that deceased proposed insured, including the amount payable for the death of that proposed insured under a rider applied for; or
2. $100,000.

Termination of Temporary Coverage

Subject to the terms of this Agreement, if temporary coverage takes effect under this Agreement, temporary coverage will terminate, and shall be of no further in force or effect, on the earliest of the following:

1. Sixty (60) days from the date shown in the Application as the date that the Application was signed by the owner. That date shall be the first day for purposes of calculating this sixty (60) day period.
2. The date an approved Life of Alabama policy on the life of a proposed insured takes effect as described in that policy, if a policy is issued in response to the Application.
3. The date Life of Alabama offers, as shown in Life of Alabama's records, the owner a Life of Alabama policy in response to, but not as applied for in, the Application.
4. The date a written or oral request to withdraw the Application is made by or on behalf of a proposed insured or the owner.
5. The date a written or oral request to terminate this Agreement is made by or on behalf of a proposed insured or the owner.
6. The date written notice is sent by Life of Alabama, as shown in Life of Alabama's records, to a proposed insured or the owner, terminating this Agreement.
7. The date written notice is sent by Life of Alabama, as shown in Life of Alabama's records, to the proposed insured or the owner, declining the Application.

Special Limitations

1. Fraud, material misrepresentation or non-disclosure in the Application will void this Agreement and limit Life of Alabama's liability to a refund of payment(s) made to Life of Alabama.
2. This Agreement shall be void if a check or draft given to the Agent is not honored when presented for payment.
3. If a proposed insured dies by suicide, whether sane or insane, Life of Alabama's liability under this Agreement is limited to a refund of the payment(s) made to Life of Alabama.
4. No temporary coverage will be provided under this Agreement to a proposed insured whose age is 66 or older on the date the Application is signed by the owner.

Payment to Life of Alabama

A check given to the Agent must be made payable to Life of Alabama. Do not make check payable to the Agent or leave the payee blank.

Entire Agreement

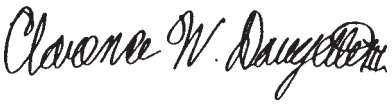
This Agreement contains the entire terms regarding temporary coverage. No one, including the Agent signing in the signature section of the Application, is authorized to waive, modify or change in writing, orally, or otherwise the terms of this Agreement or to promise or represent the terms of this Agreement other than as expressly written in this Agreement.

Governing Law

This Agreement shall be governed by and subject to the laws of the State in which this Agreement was delivered to the owner.

I, a proposed insured and/or the owner, by signing in the signature section of this Application, acknowledge and agree that I have reviewed, understand, and accept the terms of this Temporary Life Insurance Agreement, including the pre-conditions and special limitations to temporary coverage and the amount and termination of temporary coverage.

Countersigned



Clarence W. Daugette, III
President

Temporary Life Insurance Agreement Acknowledgement

Was this Temporary Life Insurance Agreement left with the owner? ☐Yes ☐No
If No, owner acknowledges that there is no temporary life insurance coverage in effect _____
(owner's initials)

X _____
Agent Signature LICOA Agent's No.

Signed at_____
City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Owner or Applicant if other than proposed insured

X_____
Signature of Spouse

X_____
Signature of Owner or Applicant if other than spouse

Temporary Life Insurance Agreement and Receipt

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If either of the above pre-conditions are not met, no temporary coverage takes effect under this Agreement even if the Agreement was left with the owner.

Temporary Life Insurance Agreement Questions

	Proposed Insured	Spouse
1. Within the past 12 months, has there been either an investigation or treatment, or both, by a physician or medical practitioner for chest pain, heart-related illness, stroke or cancer?	☐ Yes ☐ No	☐ Yes ☐ No
2. Within the past 90 days, been admitted for more than 2 consecutive days to a hospital (other than for childbirth)?	☐ Yes ☐ No	☐ Yes ☐ No
3. Within the past 90 days, has a licensed medical professional recommended a medical test, investigation or surgery, or combination thereof, which was refused to be undertaken or has not yet been undertaken?	☐ Yes ☐ No	☐ Yes ☐ No

Amount given to Agent is $_____ ☐ No amount given to Agent.

Amount of Temporary Coverage

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4. The date a written or oral request to withdraw the Application is made by or on behalf of a proposed insured or the owner.
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Entire Agreement

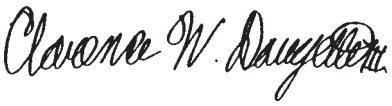
This Agreement contains the entire terms regarding temporary coverage. No one, including the Agent signing in the signature section of the Application, is authorized to waive, modify or change in writing, orally, or otherwise the terms of this Agreement or to promise or represent the terms of this Agreement other than as expressly written in this Agreement.

Governing Law

This Agreement shall be governed by and subject to the laws of the State in which this Agreement was delivered to the owner.

I, a proposed insured and/or the owner, by signing in the signature section of this Application, acknowledge and agree that I have reviewed, understand, and accept the terms of this Temporary Life Insurance Agreement, including the pre-conditions and special limitations to temporary coverage and the amount and termination of temporary coverage.

Countersigned



Clarence W. Daugette, III
President

Temporary Life Insurance Agreement Acknowledgement

Was this Temporary Life Insurance Agreement left with the owner? ☐Yes ☐No
If No, owner acknowledges that there is no temporary life insurance coverage in effect _____
(owner's initials)

X _____
Agent Signature LICOA Agent's No.

Signed at _____
City State

Date _____
Month Day Year

X _____
Signature of Proposed Insured

X _____
Signature of Owner or Applicant if other than proposed insured

X _____
Signature of Spouse

X _____
Signature of Owner or Applicant if other than spouse

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

A copy of this Agreement is to be left with the applicant. Second copy is sent with the Application.

If the applicant has an existing policy or contract, the agent or broker who initiated the application must present and read to the applicant, no later than at the time of taking the application, a completed and signed copy of the "Notice Regarding Replacement". The following procedures apply even if there is no intention to replace an existing policy or contract:

The notice must be signed by both the applicant and agent attesting that the notice has been read aloud by the agent or that the applicant did not wish the notice to be read aloud and that a copy of the notice was left with the applicant.

This notice must be completed by listing all policies or annuities proposed to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number, if available, or alternative identification such as an application or receipt number. Also, the list shall include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for a new policy.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐YES ☐ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐YES ☐ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY NUMBER	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because

_____.

I attest that the responses herein are, to the best of my knowledge, accurate:

Signed at_____
City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Owner or Applicant if other than proposed insured

X_____
Signature of Spouse

X_____
Signature of Owner or Applicant if other than spouse

X _____
Agent Signature LICOA Agent's No.

I do not want this notice read aloud to me. ____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS: Are they affordable?
Could they change?
You're older—are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES: New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?

INSURABILITY: If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
How are premiums for both policies being paid?
How will the premiums on your existing policy be affected? Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

A copy of this Agreement is to be left with the applicant. Second copy is sent with the Application.

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1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐YES ☐ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐YES ☐ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY NUMBER	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)

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City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Owner or Applicant if other than proposed insured

X_____
Signature of Spouse

X_____
Signature of Owner or Applicant if other than spouse

X _____
Agent Signature LICOA Agent's No.

I do not want this notice read aloud to me. ____ (Applicants must initial only if they do not want the notice read aloud.)

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OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

AUTHORIZATION TO HONOR CHECKS DRAWN BY AND PAYABLE TO THE LIFE INSURANCE COMPANY OF ALABAMA, GADSDEN, ALABAMA

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks drawn by and payable to the order of the Life Insurance Company of Alabama, Gadsden, Alabama provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of The Life Insurance Company of Alabama to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Name of financial institution_____ City_____ State_____

I would like the payment withdrawn on the_____ (select the 1st through the 28th) day of the month.

Checking account no. _____ OR Savings account no._____

Signature as it appears on bank records (do not print) **X**_____

AUTHORIZATION TO HONOR CHECKS DRAWN BY AND PAYABLE TO THE LIFE INSURANCE COMPANY OF ALABAMA, GADSDEN, ALABAMA

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks drawn by and payable to the order of the Life Insurance Company of Alabama, Gadsden, Alabama provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of The Life Insurance Company of Alabama to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

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Signature as it appears on bank records (do not print) **X**_____

BILLING DATA AND PAYROLL DEDUCTION AUTHORIZATION

PART I - REQUIRED ON EACH SALARY SAVINGS POLICY (***PLEASE PRINT OR TYPE***)

EFFECTIVE DATE	NAME OF EMPLOYEE	SOCIAL SECURITY NO.
DEPT. NO.	NAME OF EMPLOYER	MONTHLY PREMIUM
EMP. NO.	INDICATE TYPE OF COVERAGE	WEEKLY PREMIUM

PART II - REQUIRED IF A PREMIUM IS TO BE PAID BY EMPLOYEE

I hereby request and authorize you to deduct the premium from my wage and to transmit it to Life Insurance Company of Alabama (LICOA). These deductions are to cover the premiums on the insurance policy I have applied for if the policy is issued by LICOA.

I acknowledge that this authorization is being signed at the same time I am applying for insurance coverage with LICOA, but IN NO EVENT WILL ANY INSURANCE BE IN FORCE UNTIL THE EFFECTIVE DATE OF ANY POLICY WHICH MAY BE ISSUED BY LICOA. This authorization also allows you to increase my deduction for any premium increases on the policy which may be made by LICOA.

_____ **X** _____

DATE SIGNATURE OF EMPLOYEE

Cut along dotted line.

This Notice is to be detached, read, and retained by the Proposed Insured

FAIR CREDIT REPORT ACT NOTICE

Under Public Law 91-508, we are required to inform persons proposed for insurance that, as part of our regular underwriting procedure, an investigative consumer report may be obtained, which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with your friends, neighbors, and associates. Upon written request to the Manager-Individual Policy Department at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, Alabama 35902, further information on the nature and scope of the report will be provided. **You or any person authorized to act on your behalf are entitled to receive a copy of this Authorization Form.**

To: The Bank named on the reverse side.

The Life Insurance Company of Alabama agrees:

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
(2) In the event that any such check, draft or order shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

THE LIFE INSURANCE COMPANY OF ALABAMA, Gadsden, Alabama

President

Authorized in resolution adopted by the Executive Board of
The Life Insurance Company of Alabama on April 29, 1974

To: The Bank named on the reverse side.

The Life Insurance Company of Alabama agrees:

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
(2) In the event that any such check, draft or order shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

THE LIFE INSURANCE COMPANY OF ALABAMA, Gadsden, Alabama

President

Authorized in resolution adopted by the Executive Board of
The Life Insurance Company of Alabama on April 29, 1974

MEDICAL INFORMATION BUREAU, INC. (MIB), NOTICE Information regarding your insurability will be treated as confidential. We or our Reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. We or our reinsurers may release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com. The purpose of the bureau is to protect its members and their policyholders from the extra expense created by those who omit or conceal information relevant to their insurability. Information furnished by the Bureau may serve to alert the company to a need for further investigation but under Bureau rules cannot be used either wholly or partly as the basis for increasing the charge for or denying the issuance of insurance. Information in the Bureau gives no indication regarding the action taken on an application (i.e., whether accepted standard, accepted with increased premium, or declined).

Life Insurance Company of Alabama

302 Broad Street
Gadsden, Alabama 35901
800-226-2371

CRITICAL ILLNESS BENEFIT POLICY

OUTLINE OF COVERAGE
For Policy Form Number HH892012AR

THE POLICY PROVIDES LIMITED BENEFITS

THE POLICY IS A SPECIFIED DISEASE INDEMNITY POLICY WHICH ONLY PROVIDES BENEFITS FOR CERTAIN CRITICAL ILLNESS. IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS, CONDITION OR INCAPACITY.

THIS IS A LIMITED BENEFIT POLICY – PLEASE READ YOUR POLICY CAREFULLY - This outline of coverage provides a very brief description of some of the important features of the policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and the Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

CRITICAL ILLNESS INSURANCE COVERAGE – Policies of this category are designed to provide persons insured, restricted coverage paying ONLY when certain losses occur as a certain critical illness. Coverage is not provided for basic hospital, basic medical-surgical, or major medical or comprehensive expenses.

BENEFITS

Qualifying For Benefits
We will pay the Critical Illness Benefit selected, if a Critical Illness is Incurred (or Manifests) and is Diagnosed more than 30 days after the Effective Date. Payment of the Primary Insured's Critical Illness Benefit Maximum terminates this Policy. Payment of the Critical Illness Benefit Maximum for a Covered Person terminates coverage for that Covered Person. The Critical Illness Benefit Maximum for a Covered Person is reduced by the amount of all Critical Illness Benefit amounts paid for that Covered Person. The total of all Critical Illness Benefits payments for a Covered Person cannot exceed the Critical Illness Benefit Maximum for that Covered Person as selected. No Critical Illness Benefit is payable more than once.

Critical Illness Benefit

1. The Critical Illness Benefit Maximum is reduced by the amount of all Critical Illness Benefit amounts paid.
2. The total of all Critical Illness Benefit payments cannot exceed the Critical Illness Benefit Maximum.
3. No Critical Illness Benefit is payable more than once.
4. Payment of the Critical Illness Benefit Maximum terminates the policy.
5. On a Covered Person's attained age 70, all Critical Illness Benefits and the Critical Illness Benefit Maximum, less any benefits previously paid, will be reduced by one-half (50%).

Benefit Payment Conditions

The payment of benefits for a Critical Illness is subject to the following conditions:

1. The benefit payment is not excluded by any general or specific exclusion or limitation.
2. The Critical Illness Diagnosis is made by a legally licensed Physician during the lifetime of a Covered Person and includes diagnosis after death.

Critical Illness
In the policy, the term Critical Illness means a Heart Attack, Kidney Failure, Stroke, Major Organ Transplant, Coronary Artery Angioplasty and Coronary Artery Bypass Grafting. Benefits are not provided for any other Critical Illness.

Heart Attack Benefit
We will pay the Heart Attack Benefit if a Heart Attack is Incurred, Manifested and Diagnosed more than 30 days after the Effective Date of the policy. A Heart Attack that is Incurred during or within 24 hours of any heart, cardiac or coronary artery medical procedure is excluded.

A Heart Attack means an Acute Myocardial Infarction resulting in death of heart muscle due to inadequate blood supply. . All of the following criteria for acute myocardial infarction must be satisfied:

1. Medical documentation of typical clinical symptoms, for example, central chest pain; and
2. diagnostic increase of specific cardiac markers or elevated cardiac enzymes; and
3. new electrocardiographic changes consistent with an Acute Myocardial Infarction.
4. The Critical Illness Diagnosis of an Acute Myocardial Infarction must be made by a legally licensed Physician during the Covered Person's lifetime and includes diagnosis after death.
   Heart Attack does not mean a cardiac arrest, congestive heart failure, cardiopulmonary arrest or any condition other than an Acute Myocardial Infarction.

Kidney Failure Benefit
We will pay the Kidney Failure Benefit if Kidney Failure both Manifests and is Diagnosed more than 30 days after the Effective Date of the policy.

Kidney Failure means chronic irreversible failure of both kidneys to function, as a result of which either regular renal or peritoneal dialysis, or renal transplant is initiated. The Critical Illness Diagnosis must be made by a legally licensed Physician during the Covered Person's lifetime and includes diagnosis after death.

Stroke Benefit
We will pay the Stroke Benefit if a Stroke is Incurred, Manifested and Diagnosed more than 30 days after the Effective Date of the policy.

A Stroke means death of brain tissue due to an acute cerebrovascular event. All of the following criteria for stroke must be satisfied:

1. clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage;
2. clear evidence on a CT, MRI or similar imaging technique that a stroke has occurred; and
3. permanent neurologic deficit measured 30 days or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome.
4. The Critical Illness Diagnosis must be made by a legally licensed Physician during the Covered Person's lifetime and includes diagnosis after death.

Symptoms due to and conditions of transient ischemic attack, migraine, hypoxia, traumatic injury to brain tissue or blood vessels, and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

Major Organ Transplant Benefit
We will pay the Major Organ Transplant Benefit if more than 30 days after the Effective Date of the policy both.

1. the need for a Major Organ Transplant is first Diagnosed; and
2. the Covered Person undergoes a Major Organ Transplant.

A Major Organ Transplant means human to human organ transplant from a donor to the Insured of: bone marrow (solely for treatment of cancer or bone marrow failure), or transplant of an entire kidney, liver, heart, lung, or pancreas. Transplant of any other organs, parts of organs, tissues or cells are excluded.

Coronary Artery Angioplasty Benefit
We will pay the Coronary Artery Angioplasty Benefit if more than 30 days after the Effective Date of the policy both.

1. the need for a Coronary Artery Angioplasty is first Diagnosed; and
2. the Covered Person undergoes a Coronary Artery Angioplasty.

A Coronary Artery Angioplasty means balloon angioplasty; laser angioplasty; angioplasty and stent placement; or atherectomy; to correct narrowing or blockage of one or more coronary arteries.

Coronary Artery Bypass Grafting Benefit
We will pay the Coronary Artery Bypass Grafting Benefit if more than 30 days after the Effective Date of the policy both.

1. the need for a Coronary Artery Bypass Grafting is first Diagnosed; and
2. the Covered Person undergoes a Coronary Artery Bypass Grafting.

Coronary Artery Bypass Grafting means major open heart surgery requiring median sternotomy (division of the breast bone) to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Procedures that do not require median sternotomy are excluded, including but not limited to, minimally invasive, endoscopic, and "keyhole" heart surgery; balloon and laser angioplasty; stent procedures; and atherectomy.

Important Definitions
Covered Persons are indicated by the coverage type selected:

1) Individual: Only the Primary Insured listed on the Policy Schedule Page is covered.
2) Individual and Spouse: The Primary Insured and the Primary Insured's Legal Spouse as listed on the application or added/changed by endorsement are covered.
3) One Parent Family: The Primary Insured and all of the Primary Insured's legal Dependent Child(ren) as listed on the application or added/changed by endorsement are covered.
4) Two Parent Family: The Primary Insured, The Primary Insured's Legal Spouse as listed on the application or added/changed by endorsement and all of the Primary Insured's legal Dependent Child(ren) as listed on the application or added/changed by endorsement are covered.

Any person specifically excluded by name from coverage is NOT included as a Covered Person.

Critical Illness Benefit Maximum means the maximum total dollar amount payable under the policy. The Critical Illness Benefit Maximum is reduced, for all Covered Persons, by fifty percent (50%) on the Covered Person's attained age of 70 years.

Diagnosed or Diagnosis means a definitive identification of the Critical Illness made by a Physician (where applicable, specializing in a particular area of medicine) and supported by documentation of all appropriate and defined studies:

1. based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
2. meets any diagnostic requirements stated in the policy for the particular Critical Illness being diagnosed; and
3. performed during the lifetime of the Covered Person and includes diagnosis after death.

Effective Date means the date that the policy becomes effective.

Incur or Incurred means an event, incident, or condition that:

1. occurs on or after the Effective Date of the policy, and
2. occurs while the policy is in force, and
3. is Diagnosed during the life of the Covered Person and includes diagnosis after death and
4. is not specifically excluded by any definitions or exclusions in the policy.

Manifests or Manifested means a condition or symptom that would cause an ordinary prudent person to seek medical advice, care, or treatment.

Physician means a person who:

1. is a legally qualified medical practitioner in good standing and a Doctorate of the healing arts licensed in the United States or its territories; and
2. practices within the scope of his or her license and specialty in the United States or its territories; and
3. is not the Covered Person; or
4. is not the Covered Person's immediate family member or business associate; or
5. does not customarily reside in the same household as the Covered Person.

A Physician does NOT mean an emergency medical technician, nurse, nurse practitioner, physician's assistant, coroner or other medical personnel that does not meet the above qualifications.

Exclusions and Limitations

We will not pay benefits for a loss while being, caused by, contributed to, or resulting from:

- Any act of war, declared or undeclared, or
- Active duty in the armed forces, National Guard, or any reserve unit, or
- Engaging in a felony, or participating in any riot or civil insurrection; or
- Engaging in an illegal activity; or participating in any riot or civil insurrection; or
- Any intentionally self-inflicted injury; suicide, or suicide attempt, or
- Under the influence of alcohol (including the operation of or passenger of a motor vehicle with a blood alcohol concentration in excess of the legal limit of the state in which the accident occurs) or a controlled substance unless legally prescribed and used in the manner consistent with that prescription; or
- Any benefits for conditions diagnosed outside of the United States unless the Diagnosis and Date of Diagnosis can be confirmed in the United States by a Physician; or
- Any illness, loss, or condition specifically excluded from the definition of any Critical Illness
- Any illness, loss, or condition not stated as a covered Critical Illness in the policy.
- Any Critical Illness in which ALL of the criteria and Proof of Loss has not been received by the Company.

Renewability

You may continue the coverage provided by the policy by paying all premiums when due, until the policy anniversary on or following the expiry date, subject to the policy's termination provision.

Premium.

We reserve the right to change the premium rates for the policy. Any change in premium will be made on a premium class basis. No change in premium will become effective until 40 days after a notification is sent to your last known address, on Our Home Office Records.

Benefit Amount Selections		**Premium**
Critical Illness Base Plan		**$** _____
Critical Illness Maximum Benefit Amount		
Heart Attack Benefit	_____	
Kidney Failure Benefit	_____	
Stroke Benefit	_____	
Major Organ Transplant Benefit	_____	
Coronary Artery Angioplasty Benefit	_____	
Coronary Artery Bypass Grafting	_____	
Optional Riders		
☐ **Wellness Rider**		**$** _____
	Total Premium	**$** _____

LIFE INSURANCE COMPANY of Alabama

J. STEVEN KECK
Senior Vice President
and Secretary

HOME OFFICE
P. O. BOX 349
GADSDEN, ALABAMA 35902
Phone: (256) 543-2022

August 27, 2012

Hess Compliance Consulting, LLC
11251 SE 4th Street
Williston, FL 32696

To Whom It May Concern:

The firm of Hess Compliance Consulting, LLC is hereby authorized to submit forms, rate filings or other filings requiring actuarial certification for approval to the Department of Insurance on behalf of Life Insurance Company of Alabama. Revisions to the filings, as may be necessary to gain approval, are included in this authorization.

Sincerely,

J. Steven Keck, FSA, MAAA
Executive Vice President, Chief Operating Officer

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
12/13/2012	Replaced 12/17/2012	Form	Critical Illness Benefit Policy	12/13/2012	HH892012AR.pdf (Superceded)
12/13/2012	Replaced 12/17/2012	Supporting Document	Application	12/13/2012	MP A&H 2012.pdf (Superceded) MP LIFE 2012.pdf (Superceded)
12/13/2012	Replaced 12/17/2012	Supporting Document	Outline of Coverage	12/13/2012	OCHH892012 AR.pdf (Superceded)
11/26/2012	Replaced 12/17/2012	Form	Critical Illness Benefit Policy	12/13/2012	HH892012AR.pdf (Superceded)
10/22/2012	Replaced 12/17/2012	Supporting Document	Outline of Coverage	12/13/2012	LOA OCHH892012 Outline Critical Illness.pdf (Superceded)
10/02/2012	Replaced 12/17/2012	Form	Critical Illness Benefit Policy	11/26/2012	HH892012OK.pdf (Superceded)
09/05/2012	Replaced 12/17/2012	Form	Critical Illness Benefit Policy	10/02/2012	LOA HH892012 Critical Illness Policy - Final.pdf (Superceded)
09/05/2012	Replaced 12/17/2012	Form	Cancer Benefit Policy	10/02/2012	LOA HC882012 Cancer Policy - Final.pdf (Superceded)
09/04/2012	Replaced 12/17/2012	Supporting Document	Application	12/13/2012	LOA MP AH 2012 ONLY.pdf (Superceded) LOA MP LIFE 2012 ONLY.pdf (Superceded)

SERFF Tracking #:	*HESS-128670082*	***State Tracking #:***		***Company Tracking #:***	*AMHLOACIAR*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of Alabama*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Critical Illness*		
Project Name/Number:	*Individual Specified Disease/AMHLOACIAR*		

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/04/2012	Replaced 12/17/2012	Supporting Document	Outline of Coverage	10/22/2012	LOA OCHH892012 Outline Critical Illness.pdf OCHC882012 Outline CI Cancer.pdf (Superceded)

LICOA
Life Insurance Company of Alabama
HOME OFFICE • GADSDEN, ALABAMA 35902

Protecting your financial security

CRITICAL ILLNESS BENEFIT POLICY

LIFE INSURANCE COMPANY OF ALABAMA agrees to pay the benefits according to the provisions of this Policy. All benefits are subject to its provisions, exclusions and limitations. This Policy is a legal contract between You and Us.

Signed for the Company at Gadsden, Alabama.

Secretary President

CONSIDERATION

This Policy is issued to You in consideration of Your application and the receipt of the first premium. This Policy is a legal contract between You and Us. Your Policy is effective at 12:01 a.m. on the Effective Date in the time zone of Your home address as indicated on the Policy Schedule page.

NOTICE OF RIGHT TO EXAMINE POLICY

You should read this entire contract carefully and refer to the DEFINITIONS section to understand the meaning of defined words. The application and any amendments or riders are a part of this contract. You must review and give special attention to make sure all of the information in the application and amendments are accurate and complete. You notify Us of any information that is inaccurate, incomplete or omitted within thirty (30) days after delivery of this Policy. You may return this Policy within thirty (30) days after the delivery if You are not satisfied with it for any reason to: Life Insurance Company of Alabama, PO Box 349, Gadsden, AL 35902. The return of this Policy will void it from the Effective Date and any premium We receive will be refunded.

GUARANTEED RENEWABLE TO AGE 90
SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS BY CLASS

You may continue the coverage provided by this Policy by paying all premiums when due, until the Policy anniversary on or following the Expiry Date, subject to the Policy's Termination provision. We reserve the right to change the premium rates for this Policy. Any change in premium will be made on a premium class basis. No change in premium will become effective until 40 days after a notification is sent to Your last known address, on Our Home Office Records.

THIS IS A SPECIFIED DISEASE POLICY, WHICH ONLY PROVIDES BENEFITS FOR THE DIAGNOSIS OF ILLNESSES SPECIFIED AND DEFINED IN THIS POLICY. IT DOES NOT PAY BENEFITS FOR LOSS FROM ANY OTHER CAUSE. THIS POLICY DOES NOT CONTAIN DEATH BENEFITS. IT CONTAINS WAITING PERIODS EXCLUSIONS AND LIMITATIONS.

THIS IS A LIMITED BENEFIT POLICY
READ IT CAREFULLY WITH THE OUTLINE OF COVERAGE

TABLE OF CONTENTS

POLICY SCHEDULE **[policy no]**

FORM NO.	DESCRIPTION	UNITS	PLAN	PREMIUM
[HH89]	[CRITICAL ILLNESS]	[XXX.XXX]	[HH89]	[$XXX.XX]

TOTAL ANNUAL PREMIUM **[$XXX.XX]**

RENEWAL PREMIUMS

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY
[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]

***THE FOLLOWING BENEFITS ARE PAID FOR COVERAGE PROVIDED BY*:**

1. **[CRITICAL ILLNESS BENEFITS** **BENEFIT AMOUNT (Based On XXX.XXX Units)**

	Primary Insured	Spouse	Per Child
Heart Attack	$ XXX	$ XXX	$ XXX
Coronary Artery Bypass Grafting	$ XXX	$ XXX	$ XXX
Coronary Artery Angioplasty	$ XXX	$ XXX	$ XXX
Stroke	$ XXX	$ XXX	$ XXX
Kidney Failure	$ XXX	$ XXX	$ XXX
Major Organ Transplant	$ XXX	$ XXX	$ XXX
CRITICAL ILLNESS BENEFIT MAXIMUM	$ XXX	$ XXX	$ XXX]

On a Covered Person's attained age 70, all Critical Illness Benefits and the Critical Illness Benefit Maximum, less any benefits previously paid, will be reduced by one-half (50%), for that Covered Person.

2. **[Optional Rider[(s)]]**

POLICY NUMBER:
[xxxxxxxxxx]

INSURED:
[John Doe]
[123 WALKING WAY]
[ANYTOWN, AL, 12345]

EFFECTIVE DATE:
[MM/DD/YYYY]

ISSUE AGE: [XX] SEX:[MALE]
SMOKING STATUS: [NON-SMOKER]
POLICY WAITING PERIOD: [30 days for all Benefits]

PREMIUM: [$XXX.XX]
PAYABLE EVERY: [MONTH]
COVERAGE TYPE: [INDIVIDUAL]

DEFINITIONS

As used in, and for the purposes of this Policy, the terms listed below will have the meanings as defined. The plural use of a term will share the same meaning as the singular.

AGE means the attained age as of the Covered Person's last birthday.

CLINICAL DIAGNOSIS means a Diagnosis and identification of a Covered Event or Covered Condition based on observation and history, diagnostic and laboratory studies, and symptoms.

COVERED EVENT or COVERED CONDITION means Heart Attack, Kidney Failure, Stroke, Major Organ Transplant, Coronary Artery Angioplasty, and Coronary Artery Bypass Grafting as each is defined in this Policy, including any applicable limitations and exclusions.

COVERED PERSONS are indicated by the Coverage Type as shown on the Policy Schedule Page as follows:

1) Individual: Only the Primary Insured listed on the Policy Schedule Page is covered.
2) Individual and Spouse: The Primary Insured and the Primary Insured's Legal Spouse as listed on the application or added/changed by endorsement are covered.
3) One Parent Family: The Primary Insured and all of the Primary Insured's legal Dependent Child(ren) as listed on the application or added/changed by endorsement are covered.
4) Two Parent Family: The Primary Insured, the Primary Insured's Legal Spouse as listed on the application or added/changed by endorsement and all of the Primary Insured's legal Dependent Child(ren) as listed on the application or added/changed by endorsement are covered.

Any person specifically excluded by name from coverage is NOT included as a Covered Person.

CRITICAL ILLNESS means only the illnesses or procedures listed in the Policy Schedule under "Critical Illness Benefits"

CRITICAL ILLNESS BENEFIT MAXIMUM means the maximum total dollar amount payable under this Policy stated in the Policy Schedule. The Critical Illness Benefit Maximum is reduced, for all Covered Persons, by fifty percent (50%) on the Covered Person's attained age of 70 years.

DATE OF DIAGNOSIS means the date the Covered Event or Covered Condition of a Critical Illness is first Diagnosed. It is NOT the date the Diagnosis is communicated to a Covered Person.

DEPENDENT CHILD OR DEPENDENT CHILDREN means any unmarried child (natural, step or adopted) of Yours who:

1) is less than nineteen (19) years old and living with You; or
2) is less than twenty-four (24) years old and attending an accredited school as a full time student. Such child must be legally dependent upon You for principal support and maintenance; or
3) is or becomes incapable of self-support because of mental or physical handicap while covered under this Policy and prior to attaining limiting age for Dependent Child(ren) under (1) or (2) above. The child must be legally dependent upon You for support and maintenance. We must receive proof of incapacity after coverage would otherwise terminate. Coverage will then continue as long as Your insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age twenty-four (24) at the Company's expense; or
4) is not living with You, but You are legally required to support such child, and the child would otherwise qualify under (1), (2) or (3) above.

The term Dependent Child(ren) does NOT include grandchild(ren) unless required by law.
Proof of legal status may be required from time to time on covered Dependent Child(ren).

DEFINITIONS (Continued)

DIAGNOSED or **DIAGNOSIS** means a definitive identification of the Critical Illness made by a Physician (where applicable, specializing in a particular area of medicine) and supported by documentation of all appropriate and defined studies:

1. based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
2. meets any diagnostic requirements stated in this Policy for the particular Critical Illness being diagnosed; and
3. performed during the lifetime of the Covered Person and includes a diagnosis after death.

EFFECTIVE DATE means the date that this Policy becomes effective. The Effective Date is stated on the Policy schedule page.

FRAUDULENT MISREPRESENTATIONS means information on the application that is stated incorrectly for the purposes of obtaining this Policy.

IMMEDIATE FAMILY OR **IMMEDIATE FAMILY MEMBER** includes anyone related to You or Your Legal Spouse in the following manner: spouse; brothers or sisters (including stepbrothers, stepsisters, half-brothers and half-sisters);children (including stepchildren); parents (including stepparents); grandparents (including step grandparents);grandchildren (including step-grandchildren); aunts and uncles; nieces and nephews; and spouses, as applicable, of any of the above.

INCUR or INCURRED means an event, incident, or condition that:
1. occurs on or after the Effective Date of this Policy, and
2. occurs while this Policy is in force, and
3. is Diagnosed during the life of the Covered Person and after death, and
4. is not specifically excluded by any definitions or exclusions in this Policy.

LEGAL SPOUSE means Your spouse as recognized by federal law. Once this Policy has been issued, any consideration of an addition of a spouse, whether by first marriage or remarriage, requires the submission of a completed application and is subject to Our approval. Spouse coverage terminates upon divorce of marriage. Proof of legal status may be required upon Our request from time to time on a covered spouse.

MANIFESTS or MANIFESTED means a condition or symptom that would cause an ordinary prudent person to seek medical advice, care, or treatment.

MONTH means a calendar month.

PHYSICIAN means a person who:
1. is a legally qualified medical practitioner in good standing and a Doctorate of the healing arts licensed in the United States or its territories; and
2. practices within the scope of his or her license and specialty in the United States or its territories; and
3. is not the Covered Person; or
4. is not the Covered Person’s Immediate Family Member or business associate; or
5. does not customarily reside in the same household as the Covered Person.

A Physician does NOT mean an emergency medical technician, nurse, nurse practitioner, physician’s assistant, coroner or other medical personnel that does not meet the above qualifications.

PRIMARY INSURED means the person named in the Policy Schedule Page.

DEFINITIONS (Continued)

REINSTATEMENT DATE means the date coverage under this Policy and any attached Riders becomes effective following Reinstatement. This date will be the date of Our approval in writing of the reinstatement of any coverage.

WE, OUR, COMPANY or US means Life Insurance Company of Alabama

YOU or YOUR refers to the Primary Insured named in the Policy Schedule.

CRITICAL ILLNESS BENEFITS

We will pay the Critical Illness Benefit amount stated in the Policy Schedule (subject to all applicable Policy provisions), if a Critical Illness is both Incurred (or Manifests, as stated in the Policy), and is Diagnosed more than 30 days after the Effective Date. Payment of the Primary Insured's Critical Illness Benefit Maximum terminates this Policy. Payment of the Critical Illness Benefit Maximum for a Covered Person terminates coverage for that Covered Person. The Critical Illness Benefit Maximum for a Covered Person is reduced by the amount of all Critical Illness Benefit amounts paid for that Covered Person. The total of all Critical Illness Benefit payments for a Covered Person cannot exceed the Critical Illness Benefit Maximum for that Covered Person as stated in the Policy Schedule. No Critical Illness Benefit for a Covered Person is payable more than once.

On a Covered Person's attained age 70, all Critical Illness Benefits and the Critical Illness Benefit Maximum, less any benefits previously paid, will be reduced by one-half (50%), for that Covered Person.

BENEFIT PAYMENT CONDITIONS

The payment of benefits for a Critical Illness stated in the Policy Schedule is subject to the following conditions:

(a) the Critical Illness Incurs and/or Manifests as stated in the Policy; and

(b) the Critical Illness is Diagnosed, Incurred and Manifested after the Policy Waiting Period following the Effective date of this Policy; and

(c) the benefit payment is not excluded by any general or specific exclusion or limitation; and

(d) the Critical Illness Diagnosis is made by a legally licensed Physician during the lifetime of the Insured and includes after death.

(e) All required Proofs of Loss must be received by the Company.

CRITICAL ILLNESS BENEFITS (Continued)

HEART ATTACK

For the purposes of this Policy, Heart Attack means an Acute Myocardial Infarction resulting in death of heart muscle due to inadequate blood supply. .

All of the following criteria for acute myocardial infarction must be satisfied:

1. Medical documentation of typical clinical symptoms, for example, central chest pain; and
2. diagnostic increase of specific cardiac markers or elevated cardiac enzymes; and
3. new electrocardiographic changes consistent with an Acute Myocardial Infarction; and
4. the Critical Illness Diagnosis of an Acute Myocardial Infarction must be made by a legally licensed Physician during the Covered Person's lifetime and includes after death.

Heart Attack does **not** mean a cardiac arrest, congestive heart failure, cardiopulmonary arrest or any condition other than an Acute Myocardial Infarction.

If a Heart Attack is Incurred, Manifested and Diagnosed more than 30 days after the Effective Date, We will pay the Heart Attack Benefit stated in the Policy schedule.

Heart Attack that is Incurred during or within 24 hours of any heart, cardiac or coronary artery medical procedure is excluded.

KIDNEY FAILURE

For the purposes of this Policy, Kidney Failure means chronic irreversible failure of **both** kidneys to function, as a result of which either regular renal or peritoneal dialysis, or renal transplant is initiated. The Critical Illness Diagnosis must be made by a legally licensed Physician during the Covered Person's lifetime and includes after death.

KIDNEY FAILURE BENEFIT

If Kidney Failure both Manifests and is Diagnosed more than 30 days after the Effective Date, We will pay the Kidney Failure Benefit stated in the Policy Schedule.

STROKE

For the purposes of this Policy, Stroke means death of brain tissue due to an acute cerebrovascular event. All of the following criteria for stroke must be satisfied:

1. clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage; and
2. clear evidence on a CT, MRI or similar imaging technique that a stroke has occurred; and
3. permanent neurologic deficit measured 30 days or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome; and
4. the Critical Illness Diagnosis must be made by a legally licensed Physician during the Covered Person's lifetime and includes after death.

Symptoms due to and conditions of transient ischemic attack, migraine, hypoxia, traumatic injury to brain tissue or blood vessels, and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

STROKE BENEFIT

If a Stroke is Incurred, Manifested and Diagnosed more than 30 days after the Effective Date, We will pay the Stroke Benefit stated in the Policy Schedule.

MAJOR ORGAN TRANSPLANT

For the purposes of this Policy, Major Organ Transplant means human to human organ transplant from a donor to the Covered Person of: bone marrow (solely for treatment of cancer or bone marrow failure), or transplant of an entire kidney, liver, heart, lung, or pancreas. Transplant of any other organs, parts of organs, tissues or cells are excluded.

MAJOR ORGAN TRANSPLANT BENEFIT

We will pay the Major Organ Transplant Benefit stated in the Policy schedule, if more than 30 days after the Effective Date both:

(a) the need for a Major Organ Transplant is first Diagnosed; and
(b) the Covered Person undergoes a Major Organ Transplant.

CORONARY ARTERY ANGIOPLASTY

For the purposes of this Policy, Coronary Artery Angioplasty means balloon angioplasty; laser angioplasty; angioplasty and stent placement; or atherectomy; to correct narrowing or blockage of one or more coronary arteries.

CORONARY ARTERY ANGIOPLASTY BENEFIT

We will pay the Coronary Artery Angioplasty Benefit stated in the Policy schedule if, more than 30 days after the Effective Date both:

(a) the need for a Coronary Artery Angioplasty is first Diagnosed; and
(b) the Covered Person undergoes a Coronary Artery Angioplasty.

All diagnostic procedures including, but not limited to, arteriograms, angiograms and cardiac catheterization are excluded.

This benefit is payable only once in the Covered Person's lifetime.

CORONARY ARTERY BYPASS GRAFTING

For the purposes of this Policy, Coronary Artery Bypass Grafting means major open heart surgery requiring median sternotomy (division of the breast bone) to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Procedures that do not require median sternotomy are excluded, including but not limited to, minimally invasive, endoscopic, and "keyhole" heart surgery; balloon and laser angioplasty; stent procedures; and atherectomy.

CORONARY ARTERY BYPASS GRAFTING BENEFIT

We will pay the Coronary Artery Bypass Grafting Benefit stated in the Policy schedule if, more than 30 days after the Effective Date both:

(a) the need for Coronary Artery Bypass Grafting is first Diagnosed; and
(b) the Covered Person undergoes Coronary Artery Bypass Grafting.

This benefit is payable only once in the Covered Person's lifetime**.**

RIGHT TO EXAMINE FOR ALL CRITICAL ILLNESSES

We reserve the right to conduct a physical examination of the Covered Person and/or review any Critical Illness Diagnosed by a Physician of Our choosing. Any expenses incurred for this examination will be paid by the Company. This Physician must:

(a) have specialty training and board certification in the field of Medicine specific to the Critical Illness being Diagnosed; and

(b) must follow all routinely accepted procedures and protocols in the Diagnosis of the Critical Illness.

EXCLUSIONS

We will NOT pay benefits for a loss while being, caused by, contributed to, or resulting from:

- Any act of war, declared or undeclared; or
- Active duty in the armed forces, National Guard, or any reserve unit; or
- Engaging in a felony, or participating in any riot or civil insurrection; or
- Engaging in an illegal activity; or participating in any riot or civil insurrection; or
- Any intentionally self-inflicted injury; suicide, or suicide attempt; or
- Under the influence of alcohol (including the operation of or passenger of a motor vehicle with a blood alcohol concentration in excess of the legal limit of the state in which the accident occurs) or a controlled substance unless legally prescribed and used in the manner consistent with that prescription; or
- Any benefits for conditions diagnosed outside of the United States unless the Diagnosis and Date of Diagnosis can be confirmed in the United States by a Physician; or
- Any illness, loss, or condition specifically excluded from the definition of any Critical Illness; or
- Any illness, loss, or condition not stated as a covered Critical Illness in this Policy; or
- Any Critical Illness in which ALL of the criteria and Proof of Loss has not been received by the Company.

TERMINATION OF INSURANCE

Insurance coverage for You and Your Legal Spouse, if covered, will continue until the earliest of:

1) the Primary Insured's 90th birthday; or
2) the date any premium for this Policy is in default beyond the end of its Grace Period; or
3) the premium due date following Your written request for its termination.

In the event of Your death, coverage on any remaining Covered Persons will not terminate provided We receive a copy of Your death certificate and Written Notice to continue coverage within thirty (30) days of the date of Your death. If Your covered Legal Spouse or Dependent Child dies, You may request in writing to remove them from Your coverage.

If Your Legal Spouse is a Covered Person under this Policy and You and Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage, insurance coverage provided by this Policy on Your former Legal Spouse will automatically terminate on the 61st day following the date of the decree of the dissolution of marriage subject to the Right of Conversion provision.

Insurance coverage on a Dependent Child will terminate automatically on the earliest of the following:

1) the date of the Dependent Child's marriage; or
2) the Dependent Child's nineteenth (19th) birthday, if not a full-time student at an accredited school; or
3) the Dependent Child's twenty-fourth (24th) birthday, if a full-time student at an accredited school and legally dependent on You for principal support and maintenance.

Insurance coverage will not terminate due to the Dependent Child's age if the child is both:

1) incapable of self-sustaining employment because of mental or physical handicap; and
2) currently dependent upon You for support and maintenance.

You ***must*** provide proof of the Dependent Child's mental or physical handicap and dependence upon You after coverage would otherwise terminate in order for coverage to continue under this Policy. Proof of continued incapacity and dependency ***must be*** furnished at Our request.

Termination of Dependents is subject to the Right of Conversion provision.

RIGHT OF CONVERSION

If You and Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage and Your Legal Spouse was a Covered Person under this Policy, then Your former Legal Spouse may apply and receive, without evidence of insurability, a Policy providing coverage NOT greater than the terminated coverage. To obtain the Policy, Your former Legal Spouse must make application to Us within sixty (60) days following the date of the decree of dissolution of marriage. The Primary Insured under this Policy at the time of the dissolution of marriage shall remain the Primary Insured under this Policy. Coverage terminates automatically for the former Legal Spouse on the 61st day following the date of the decree of the dissolution of marriage. Any covered Dependent Children may be covered under either Policy, but NOT both.

A Covered Person whose dependency terminates and who desires to continue coverage as a Primary Insured under a separate Policy may do so by notifying Us of the request in writing. The Dependent Child will have the right to continue coverage as the Primary Insured under a separate Policy providing coverage NOT greater than the previous coverage without a requirement for evidence of insurability and without interruption in coverage. To obtain the Policy, the Dependent Child must make application to Us after the termination of insurance under this Policy.

In order to be considered for coverage, any Legal Spouse or Dependent Child not listed on the initial application must make written application.

GENERAL PROVISIONS

ENTIRE CONTRACT

This Policy, with the attached application, any other pages, amendments, or endorsements attached, and any application for reinstatement, are the entire contract between You and Us. This contract is made in consideration of Your application and payment of premiums as required. We rely on all statements in the application and any application for reinstatement as being true to the best of Your knowledge. No change to this Policy will be valid unless it is in writing and signed by an authorized Officer of Life Insurance Company of Alabama. No agent or other representative has authority to change or waive any Policy provisions or extend the time for paying a premium.

PAYMENT OF PREMIUMS

The due date of the initial premium is the Policy Effective Date. The initial premium may be paid to Our Home Office or to one of the Company's authorized agents. Premiums after the initial premium must be paid to Our Home Office at P.O. Box 349, Gadsden, AL 35902. Upon receipt of Your death certificate, We will refund any premium paid for any monthly period following the date of death. The refund may be paid to Your estate or designated Beneficiary. Upon receipt of Your written notice to discontinue coverage, We will refund any premium paid for any monthly period following the date We received the written notice from You. The refund may be paid to You.

This Policy is not effective until the Effective Date regardless of the date of the first premium payment if any premium is paid prior to the Effective Date. Any premium received prior to issue of the Policy will be held pending issue of the Policy. If the Policy is not issued by Us, We will refund any premium being held. If We or any third party on Our behalf receive premiums by any method (including payroll deduction and bank draft) prior to the issue of this Policy, We assume NO liability for coverage until this Policy is issued by Us. Premiums must be paid in United States currency.

GRACE PERIOD

This Policy has a thirty (30) day Grace Period for paying premium. This means if a renewal premium is not paid by the date due, it may be paid during the following thirty (30) days. Any otherwise payable claim incurred during the Grace Period will NOT be paid until the past due premiums are paid provided the Policy has not lapsed or terminated.

LAPSE

Your Policy will lapse if any premium is not paid before the end of the Grace Period. The date of lapse will be the date that the unpaid premium was due. Your Policy will terminate upon lapse as of the last date to which premiums have been paid and provide NO further benefits.

GENERAL PROVISIONS (Continued)

REINSTATEMENT

If Your Policy lapses, You may request to reinstate it by:

1. submitting a written application for reinstatement within 60 days after the end of the Grace Period; and
2. providing any additional evidence of insurability as We may require; and
3. paying all required premium.

If We approve Your request for reinstatement, coverage will become effective as of the Reinstatement Date. Unless we have previously sent you a written notice of disapproval, the Policy will be reinstated on the 45th day after Our receipt of the required evidence of insurability or such earlier date that We approve such evidence.

We will not pay benefits for any Critical Illness that Incurs or Manifests, whichever is applicable as stated in this Policy, and/or is Diagnosed: before the end of 30 days after the Reinstatement Date.

Your rights and Our obligations under this Policy will be the same as before the Policy lapsed subject to the Reinstatement and Incontestable provisions.

If You do not request a reinstatement within 90 days from the date any unpaid premium was due, this Policy will remain terminated and no further benefits will be provided.

UNEARNED PREMIUM REFUND

If You die before the end of a Premium Period for which premium has been paid, We will refund the portion of premium, prorated monthly, that was applied to coverage for the time period beyond the end of the month in which death occurred.

NOTICE OF CLAIM

You must provide Us with written notice of claim within 60 days from the Date of Diagnosis, or as soon as reasonably possible. You must provide notice of claim at Our Home Office. Your notice of claim must include the Covered Person, Your name, address, the Policy Number, and the Covered Condition or Covered Event for which the Covered Personis claiming

CLAIM FORMS

When We receive Your notice of claim, we will provide You with the forms required to file a claim. If you do not receive the forms within 15 days, You will have met the time frame required for filing Your claim. if You have provided Us with a written statement of the nature and extent of Your loss and sufficient Proof of Loss within the time allowed for filing a Proof of Loss.

PROOF OF LOSS

You must provide Us with written Proof of Loss determined to be satisfactory to Us within 90 days from the Date of Diagnosis. If it is not reasonably possible for You to provide written Proof of Loss within the stated time, Your claim will not be affected if You provide the written Proof of Loss as soon as reasonably possible but in no event later than 12 months from the Date of Diagnosis.

Proof of Loss includes the claim form (or written statement as noted in Claim Forms section above), plus appropriate evidence needed to establish benefit eligibility, which may include, but not limited to, physician or hospital records, histo-pathological reports, operative reports and test reports.

You must provide to Us any authorizations to obtain medical records or other information needed to evaluate your claim.

TIME OF PAYMENT OF CLAIMS

We will pay benefits within thirty (30) working days once We receive sufficient written Proof of Loss. If We do not pay benefits upon receipt of your claim, We shall have thirty (30) working days thereafter within which to mail to You a letter or notice which states the reasons We have for not paying the claim, either in whole or in part, and which also gives You a notice of any documents or other information needed to process the claim. When We have received sufficient written Proof of Loss from You, We shall then have thirty (30) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

PAYMENT OF CLAIMS

We will pay all benefits to You; benefits under this Policy are not subject to assignment. Upon receipt of Your death certificate, any benefits that have not been paid at the time of Your death may be paid to Your estate or Your designated Beneficiary. We have the right to pay up to $1,000 of those benefits to any Immediate Family Member who We believe is justly entitled to such payment. If We make a payment under this provision in good faith, We will be released from liability to the extent of the payment.

LEGAL ACTIONS

No legal action may be brought to recover benefits on this Policy before 60 days after We have received sufficient written Proof of Loss. No legal action may be brought against us more than two (2) years from the date written Proof of Loss was required to be provided.

AGE AND GENDER

If a Covered Person's Age or Gender is not correct as shown in this Policy, all benefits payable under this Policy will be such as the premium paid would have purchased at the correct Age or Gender. If the correct age is such that we would have obtained additional underwriting requirements or would not have issued this Policy, We will only be liable for a refund of any premiums paid for the period for which there was no coverage.

CONTESTABLE PERIOD

After two (2) years from the Effective Date (or the Reinstatement Date, if the Policy has been reinstated), only Fraudulent Misstatements, made by You in the application (or reinstatement application) shall be used to void this Policy or to deny a claim with a Date of Diagnosis after the expiration of such two (2) year contestable period. The Date of Diagnosis determines whether or not a claim is within the Contestable Period, NOT when the claim is received by Us. Only Fraudulent Misstatements, made by You on the Application (or reinstatement application) may be used by Us to void this Policy or to deny a claim with a Date of Diagnosis within two (2) years after the Effective Date or within two (2) years after the Reinstatement of this Policy.

EFFECTIVE DATE

This Policy's Effective Date is the date shown on the Policy Schedule. This Policy will take effect at 12:01 AM in the time zone of Your last known address, on our Home Office records on the Effective Date. This Policy will terminate at 11:59 PM in the time zone of Your last known address, on our Home Office records on the date of termination. If this Policy lapses and is reinstated, the Effective Date is as described in the Reinstatement Provision.

GENERAL PROVISIONS (Continued)

TERMINATION

This Policy will terminate on the earliest of:

(a) the date on which this Policy lapses or terminates; or
(b) the date that the Primary Insured's Critical Illness Benefit Maximum is paid; or
(c) any premium due date requested by You in writing to terminate this Policy; or
(d) the end of the Grace Period following the due date for which a premium was not paid; or
(e) the death of the Primary Insured; or
(f) The Primary Insured's age 90.

OWNER

The Insured is the Owner of this Policy unless later changed.

As Owner, You may exercise all rights in this Policy while the Insured Person is living. If You are without legal capacity, We will allow Your rights to be exercised by:

(a) a legally appointed Guardian responsible for Your property; or
(b) a person who We determine is responsible for Your welfare and support.

To exercise Your rights, You must follow the procedures stated in this Policy. All elections, designations, changes and requests must be made in writing and in a form acceptable to Us.

If You change Your beneficiary, address, or request any other action by Us, You should do so on the form prepared for each purpose. You may obtain such forms from Our Home Office at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, AL 35902.

BENEFICIARY

The beneficiary designated by You in the application or later changed on Our records will receive any benefits unpaid at Your death. Each beneficiary is classified as a Primary or Contingent Beneficiary. All surviving beneficiaries of the same class will share equally in any payments to that class, unless otherwise designated by You.

If no stated beneficiary is living at the time of Your Death, We will pay:

(a) the executor or administrator of Your estate; or
(b) Your spouse, child, or parent who We determine is entitled to payment

CHANGE OF OWNER OR BENEFICIARY

While the Insured Person is living, You may change:

(a) the Owner; or
(b) a Beneficiary designation, if it is not restricted by a previous designation.

We require that any change be endorsed by an authorized Officer of Our Company. Any change will be effective the date of Our endorsement. No agent or other representative has authority to endorse this Policy.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy that, on the coverage effective date, conflicts with any laws of the state where You lived when this Policy was issued, is amended to conform with the law.

APPLICATION FOR A&H INSURANCE - PART 1

Please Use Dark Ink Suitable for Photocopying.

Life Insurance Company of Alabama

P. O. Box 349 • Gadsden, Alabama 35902

Proposed Insured

1. NAME (Last, Suffix, First, M.I.) _____

BIRTHDATE ☐☐/☐☐/☐☐☐☐ STATE OF BIRTH ☐☐ SSN# ☐☐☐-☐☐-☐☐☐☐

If eligible for Medicare, deliver appropriate Medicare disclosure found on page 11

HEIGHT ☐'☐☐" WEIGHT ☐☐☐ MALE ☐ FEMALE ☐ _____ ☐☐ ISSUE STATE

Driver License #

ADDRESS _____

CITY _____ STATE ☐☐ ZIP ☐☐☐☐☐

EMAIL _____

PHONE ☐☐☐-☐☐☐-☐☐☐☐ PHONE #2 ☐☐☐-☐☐☐-☐☐☐☐

INSURED'S EMPLOYER _____ EMPLOYMENT DATE ☐☐/☐☐/☐☐☐☐

OCCUPATION _____

Describe and give exact duties

2. Has any person proposed for insurance used tobacco in any form within the last 24 months? Yes ☐ No ☐

3. Are all persons proposed for insurance citizens of U.S.A? Yes ☐ No ☐

Dependents

4. NAME	DATE OF BIRTH Mo.	Day	Yr.	STATE OF BIRTH	GENDER (M / F)	SOCIAL SECURITY NUMBER	HEIGHT (FT. IN.)	(LBS.) WEIGHT
PROPOSED LEGAL SPOUSE								
PROPOSED LEGAL CHILDREN								

If additional children, use a separate sheet of paper. Signed and dated by the Insured.

5. Do you have a current Medicaid eligibility card or other state sponsored insurance program? ☐ Yes ☐ No

DETAILS OF questions 2 - 20 answered "yes": Include question #, names and addresses of physicians and individuals to whom the history pertains in PART 8.

6. Has any person listed above and proposed for coverage ever tested positive for exposure to Human Immunodeficiency Virus (HIV) infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by Human Immunodeficiency Virus (HIV) infection or other sickness or condition derived from such infection?

☐ Yes ☐ No

HOME OFFICE USE

Payment Information

7. PAYMENT MODE *(Monthly Direct Bill Not Available)*

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

☐ Bank Draft ☐ Payroll Deduction ☐ Direct Bill

☐ Payment with app $_____ ☐ Draft first payment

Additional details_____

BILLING ADDRESS INFORMATION

☐ Proposed Insured's address ☐ Primary Owner's address

☐ Other Premium Payor's / Alternate billing address *(details below)*

Name _____

Street _____

City _____ *State*____ *ZIP*_____

☐ *Special arrangements* _____

If Bank Draft Payment is chosen, complete Authorization to Honor Checks on page 12

Existing Insurance

8. EXISTING INSURANCE

Will the policy(s) applied for replace any insurance in force on any proposed covered person? Yes ☐ No ☐

If YES, complete and submit attached replacement form (found on page 9) along with this application and list all in force insurance coverage(s) below.

Insured's Name	Company	Owner	Replacement	Amount	Year Issued
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		

Beneficiary Designation

9.	Name and Address	Relationship		%
Insured			Primary	
Insured			Contingent	
Spouse			Primary	
Spouse			Contingent	

If additional beneficiaries, use a separate sheet of paper. Signed and dated by the Insured.

APPLICATION FOR A&H INSURANCE - PART 3

CANCER INDEMNITY *☐ Advantage *☐ Choice
Health & Wellness Benefit ☐ $100 ☐ $50
Daily Room ☐ $300 ☐ $200 ☐$100
Rad. & Chemo. ☐ Option A ☐ Option B ☐ Option C
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
*Answer Question 11 $_____

First Occurrence Rider ☐ 2 Units ☐ 1 Unit / ☐ Level ☐ Building
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
$_____

Intensive Care Benefit: I75 ☐ *Rider ☐ ✤Stand Alone
☐ $300 ☐ $450 ☐ $600 ☐ Other _____ $_____
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
*Answer Question 12 ✤Answer Questions 12, 15 & 16

Specified Disease Benefit Rider* $_____
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
*Answer Question 13 Cancer Indemnity Total$_____

INPATIENT + OUTPATIENT HOSPITAL INDEMNITY PLAN*
☐ Payroll Only Plan (HI67) ☐ Individual Non-Payroll Plan (HI68)
☐ Individual ☐ One Parent ☐ Emp. & Spouse ☐ Two Parent
Daily Hospital Benefit $_____
OPTIONAL BENEFITS: Initial Conf. $_____
Surg. Benefit $_____ Emer. Acc. $_____
Outpat. Sickness $_____ Other $_____
Major Injury (Broken Bones) Units ☐ 1 ☐ 2 ☐ 3
*Record Height & Weight in Part 1 & Answer Questions 10(a) & 15 - 20
$_____

Intensive Care Benefit: I63*
☐ $300 ☐ $450 ☐ $600 ☐ Other _____ $_____
☐ Individual ☐ One Parent ☐ Two Parent
*Answer Question 12
Inpatient + Outpatient Plan Total $_____

VOLUNTARY GROUP DENTAL INSURANCE
☐ Plan I ☐ Plan II
☐ Children Orthodontic Care Rider [☐ Vision & Hearing Rider]
☐ Employee ☐ Employee/Children ☐ Family
*Answer Question 14 Dental Total $_____

CRITICAL ILLNESS
☐ Cancer Benefits** $_____ FACE AMOUNT
☐ Heart & Stroke Benefits* $_____ FACE AMOUNT
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
$_____
**Answer Questions 15 - 19
*Record Height & Weight in Part 1 Answer Questions 15 - 19

Intensive Care Benefit: I75 ☐ *Rider ☐ ✤Stand Alone
☐ $300 ☐ $450 ☐ $600 ☐ Other _____ $_____
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
*Answer Question 12 ✤Answer Questions 12, 15 & 16

Critical Illness Total $_____

ACCIDENT INCOME PROVIDER * ☐ $3000 ☐ $1500
SENIOR ACC. INCOME PROVIDER * ☐ $3000 ☐ $1500
☐ Individual ☐ One Parent ☐ Two Parent
*Answer Question 10(a) Accident Income Provider Total $_____

ACCIDENT DISABILITY PLAN * (90 Day Employment Required)
Pre-Packaged Plan ☐ 400 ☐ 600 ☐ 800 ☐ 1000 ☐ 1200
Applicant's Gross Monthly Income $_____
☐ 24 Hour Coverage ☐ Off-The-Job Only
☐ Emp ☐ Emp/Sp ☐ Emp/Ch ☐ Emp/Fam $_____
*Answer Question 10(a)

✦**BUILD A PLAN** Monthly Income $_____ FACE AMOUNT
Applicant's Gross Monthly Income $_____
☐ 24 Hour Coverage ☐ Off-The-Job Only
Benefit Period ☐ 6 months ☐ 1 Year
Accident Elimination Period ☐ 0 ☐ 7 Days
☐ Emp ☐ Emp/Sp ☐ Emp/Ch ☐ Emp/Fam $_____
*Answer Question 10(a)
✦Does not apply to Packaged Accident Disability Plans

*Sickness Disability Rider Mo. Inc. $_____ FACE AMOUNT
Benefit Period ☐ 6 month ☐ 1 year
Elimination ☐ 7 or ☐ 14 days ☐ 30 days $_____
*Record Height & Weight in Part 1 & Answer Questions 15 - 19

SICKNESS & ACCIDENT DISABILITY INCOME PLAN*
☐ Standard ☐ Preferred (90 Day Employment Required)
Monthly Disability Benefit $ _____ FACE AMOUNT
Applicant's Gross Monthly Income $ _____
Benefit Period ☐ 3 months ☐ 6 months ☐ 1 Year ☐ 2 Years
Accident Elimination Period ☐ 0 ☐ 7 ☐ 14 Days
Sickness Elimination Period ☐ 7 ☐ 14 ☐ 30 ☐ 60 ☐ 90 ☐ 180 Days
*Record Height & Weight in Part 1 & Answer Questions 10(a) and 15 - 20
$_____

Optional Benefits for Sickness &/or Accident Disability Plan:
Level of coverage (i.e. Emp, Emp/Sp, Emp/Ch, Emp/Fam) for optional benefits is determined by the level of coverage selected for base policy.

☐ ✦Initial Hospital Confinement Benefit $1000 $_____

✦Injury Treatment Benefit $_____
☐ $100 ☐ $150 ☐ $200 ☐ $250 ☐ $300

☐ ✦Health Screening Benefit $_____

✦AD&D Benefit $_____
☐ $10k ☐ $15k ☐ $20k ☐ $25k ☐ $30k

☐ Supplemental Injury Benefit $_____

☐ **Specific Loss Rider (Broken Bone)** $_____

Intensive Care Benefit* **I75** ☐ ✤Stand Alone $_____
☐ $300 ☐ $450 ☐ $600 ☐ Other _____
*Answer Question 12 ✤Answer Questions 12, 15 & 16
✦Does not apply to Pre-Packaged Accident Disability Plans
Sickness &/or Accident Disability Income Plan Total $_____

APPLICATION FOR A&H INSURANCE - PART 4

DETAILS OF questions 2 - 20 answered "yes": Include question #, names and addresses of physicians and individuals to whom the history pertains in PART 8.	PROPOSED INSURED		SPOUSE		CHILDREN	
	Yes	No	Yes	No	Yes	No
10a. Is any proposed insured currently in the hospital or receiving disability payments?	☐	☐	☐	☐	☐	☐
Answer 6, 10(a), (b) & (c) when offering a plan approved for E-Z Underwriting						
(b) Is proposed primary insured working at least 30 hours per week?	☐	☐				
(c) In the past 5 years has any proposed insured been treated by a licensed member of the medical profession for a heart attack, stroke, internal cancer, melanoma, disease or disorder of the lungs or hepatitis?	☐	☐				
11. CANCER ADVANTAGE & CHOICE	Yes	No	Yes	No	Yes	No
(a) Has any person proposed for coverage under this Policy within the last 24 months, had any elevated or rising PSA or CEA test or abnormal mammogram, pap smear, radiological exam (e.g. X-Ray, MRI, CAT Scan, sonogram, ultrasound, echo tests, etc.), biopsy or scope procedure (e.g. colonoscopy, endoscopy, etc.) or are awaiting further tests or test results?	☐	☐	☐	☐	☐	☐
(b) Has any person proposed for coverage under this Policy within the last five years, been diagnosed as having or been treated for any cancer, including skin cancer, Hodgkin's Disease and Leukemia, in any form?	☐	☐	☐	☐	☐	☐
(c) Has any person proposed for coverage under this Policy been diagnosed, as having or been treated for any cancer, including skin cancer, Hodgkin's Disease and Leukemia, in any form over five years ago?	☐	☐	☐	☐	☐	☐
If yes to question 11a or b any person(s) so designated will not be covered under the policy. If yes to question 11c, you are eligible for a policy that provides Option C Radiation & Chemotherapy Benefits and $100 per day Daily Room Benefit for the treatment of cancer. No additional amounts will be issued.						
12. INTENSIVE CARE: Has any proposed insured ever been diagnosed or treated for heart disease, heart attack, any heart condition, heart trouble or any abnormality of the heart?	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐
(a) Are you, your spouse, your fiancé, your companion or any other person to be covered by this policy/rider currently pregnant or taking fertility drugs?	☐	☐	☐	☐	☐	☐
If yes to question (a), we will issue an individual policy / rider on the adult male family member only.						
Answer Questions 12, 15, and 16 for Intensive Care Stand Alone Policy						
13. SPECIFIED DISEASE: Has any person proposed for coverage under this Policy ever had treatment or diagnosis of: • Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) • Botulism • Bubonic Plague • Cerebral Palsy • Cholera • Cystic Fibrosis • Diphtheria • Encephalitis (including encephalitis contracted from West Nile virus) • Huntington's Chorea • Lyme Disease • Malaria • Menningitis (Bacterial) • Multiple Sclerosis • Muscular Dystrophy • Myasthenia Gravis • Necrotizing Fasciitis • Osteomyelitis • Polio • Rabies • Reye's Syndrome • Rheumatic Fever • Rocky Mountain Spotted Fever • Scleroderma • Sickle Cell Anemia • Smallpox • Systemic Lupus • Tetanus • Toxic Shock Syndrome • Tuberculosis • Tularemia • Typhoid Fever • Variant Creutzfeldt-Jakob Disease (Mad Cow Disease) • Yellow Fever?	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐
14. DENTAL:	Yes	No	Yes	No	Yes	No
(a) Are all children listed legal dependents of the Proposed Insured or Spouse?	☐	☐				
(b) Is their permanent residence the residence of the Proposed Insured? *If "No", please explain in details section.*	☐	☐				
(c) Are any children listed a full-time student? *If "Yes", please explain in details section.*	☐	☐				
(d) Are all eligible family members listed above? *If "No", please explain in details section.*	☐	☐				
(e) Are you or any person to be insured covered by any other dental insurance policy or certificate? *If "Yes", please give name of the company, Policy Number, Covered Person(s) name in details section.*	☐	☐	☐	☐	☐	☐
(f) Will this policy replace existing coverage? *If yes, when will existing coverage terminate?*	☐	☐	☐	☐	☐	☐
(g) Is proposed primary insured working at least 30 hours per week?	☐	☐				

APPLICATION FOR A&H INSURANCE - PART 5

DETAILS OF questions 2 - 20 answered "yes": Include question #, names and addresses of physicians and individuals to whom the history pertains in PART 8.	PROPOSED INSURED		SPOUSE		CHILDREN	
15. HAS ANY PERSON proposed for insurance in Part 1:	Yes	No	Yes	No	Yes	No
(a) Used marijuana, narcotic, hallucinogenic or habit forming drugs not prescribed by a physician?	☐	☐	☐	☐	☐	☐
(b) Had any motor vehicle moving violations or accidents within the last two years?	☐	☐	☐	☐	☐	☐
(c) Been arrested for any reason other than moving traffic violations?	☐	☐	☐	☐	☐	☐
(d) Ever had an application for insurance or reinstatement of insurance declined, postponed, rated up or modified?	☐	☐	☐	☐	☐	☐
16. IN THE LAST 10 YEARS, HAS ANY PERSON proposed for insurance in Part 1 ever been treated by a licensed member of the medical profession for:	Yes	No	Yes	No	Yes	No
(a) Heart attack, chest pain, heart murmur, high blood pressure or any other disease of the heart, blood or blood vessels?	☐	☐	☐	☐	☐	☐
(b) Peptic ulcer, Ulcerative Colitis, Crohn's disease or any disease of the esophagus, stomach, intestines, pancreas or liver?	☐	☐	☐	☐	☐	☐
(c) Emphysema, bronchitis, asthma, Chronic Obstructive Pulmonary Disease (COPD) or any disease of the lungs or respiratory system?	☐	☐	☐	☐	☐	☐
(d) Hepatitis, diabetes, albumin, pus, blood or sugar in urine, venereal disease or any other disease of the kidneys, bladder, gland, reproductive organs or connective tissue disorder?	☐	☐	☐	☐	☐	☐
(e) Stroke, transient ischemic attack (TIA), severe headaches, fainting spells, epilepsy, paralysis, nervousness, mental disorder or any other disease of the brain, nervous system or been treated for a back or neck condition?	☐	☐	☐	☐	☐	☐
(f) Any disease or disorder of the eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐
(g) Alcohol or drug abuse?	☐	☐	☐	☐	☐	☐
(h) Any cancer or tumor including cancer of the bone marrow, blood, lymph nodes, carcinoma-in-situ, skin cancer or melanoma?	☐	☐	☐	☐	☐	☐
(i) Are you, your spouse, your fiancé, your companion or any other person to be covered by this policy/rider currently pregnant or taking fertility drugs?	☐	☐	☐	☐	☐	☐
(j) Any abnormality, deformity, disease, illness, injury or disorder not mentioned above?	☐	☐	☐	☐	☐	☐
17. OTHER THAN INDICATED ABOVE, has any person proposed for insurance in Part 1:	Yes	No	Yes	No	Yes	No
(a) Ever applied for or received a pension or disability benefit?	☐	☐	☐	☐	☐	☐
(b) Been hospitalized in the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(c) Consulted a physician during the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(d) Had a change of weight in the past year?	☐	☐	☐	☐	☐	☐
(e) Is proposed primary insured working at least 30 hours per week?	☐	☐	☐	☐	☐	☐
(f) Had an immediate family member (Father, Mother, Brothers or Sisters) with a history of diabetes, mental, nervous, heart or circulatory disorder, tuberculosis, cancer, high blood pressure, kidney disease or suicide? If so, include age(s) at diagnosis, condition, relationship, age(s) if living, age(s) at death and cause of death.	☐	☐	☐	☐	☐	☐
18. IN THE LAST 24 MONTHS, has any person proposed for insurance in Part 1 been under observation or treatment of a physician or had or been advised to have any diagnostic test, procedure, screening or surgery or awaiting test results? If yes, please provide details including date(s), reason(s) and result(s).	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐
19. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? If yes please indicate if Retired or active: list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in PART 8.	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐
20. HAS ANY PERSON proposed for insurance in Part 1:	Yes	No	Yes	No	Yes	No
(a) Flown other than as a fare-paying passenger within the last two years or considering such flying in the next two (2) years? If yes, complete Aviation Questionnaire.	☐	☐	☐	☐	☐	☐
(b) Any past, present or expected (in the next two (2) years) activity in racing, skin or sky diving, bungee jumping, base jumping, parasailing, rock climbing, hang gliding or ultra-light flying? If yes, complete Hazardous Sports Questionnaire.	☐	☐	☐	☐	☐	☐

APPLICATION FOR A&H INSURANCE - PART 6

Please provide name of doctor, practitioner, or health care facility who can provide the most complete and up-to-date information concerning any health condition listed on Part 4 of this application for any Proposed Insured.

Physician Information

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION I hereby authorize the above person(s) or entity(s) listed in above and MIB, Inc. and any prescription drug or pharmacy organization(s) to provide **Life Insurance Company of Alabama,** or its reinsurers, or to **Lab One/Exam One** on the behalf of Life Insurance Company of Alabama, information, data, or records concerning advice, care, treatment or health history provided to the person(s) named above, including, but not limited to, notes, reports, test results, x-rays, documents related to any mental conditions, cost of medical services, prognosis, physician notes of patient interviews, patient notes, pharmacy records or other data and including the full and complete clinical records, hospital charts, examination records and medical history I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol program; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition; information relating to HIV testing, HIV status, or AIDS. I understand that such information may be subject to special protections pursuant to law and that by signing this authorization, I authorize the person(s) or entity(s) listed to disclose records containing such information. Please list any special instructions. I authorize Life Insurance Company of Alabama, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.. I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at: *Life Insurance Company of Alabama, Attn: Privacy Official, PO Box 349, Gadsden, AL 35902*. I understand that the revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when my insurance coverage ends (twenty-four (24) months from the date shown below in Kentucky and Oklahoma, thirty (30) months from the date shown below in Georgia and North Carolina), if not revoked before such date. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that this authorization is needed for the purpose of gathering information for making eligibility, underwriting and risk rating determinations.

BY MY SIGNATURE(s) below I do attest that the statements and answers in all parts of this application are complete and true and will be the basis for any insurance issued. If I am eligible for Medicare, I have received the Important Notice to Persons on Medicare.

As normal procedure, the Home Office Underwriting Department may contact you by telephone to verify pertinent information contained in your application.

Arkansas Only:
Is any person to be covered for specified disease also covered by any Title XIX program Medicaid or similar coverage.
☐ Yes ☐ No

Signed at_____
City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Payor if other than Proposed Insured

AGREEMENT Terms used In this Agreement:
"You" and "Your" mean the Proposed Insured and the Applicant, if other than the Proposed Insured. "We", "us" and "our" mean the Life Insurance Company of Alabama. It is understood and agreed by you that:
(a) Any policy issued as a result of this application shall constitute a single and entire contract of insurance. Only the President, a Vice President, the Secretary or an Assistant Secretary of the Company may make a contract on its behalf. No waiver or modification of a contract provision or any of the Company's rights or requirements shall be binding upon the Company unless it is in writing signed by one of such officers. NEITHER THE AGENT WHOSE SIGNATURE APPEARS BELOW, NOR ANY OTHER AGENT OR BROKER, NOR ANY MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS, PASS UPON INSURABILITY, MAKE OR MODIFY CONTRACTS OR WAIVE ANY OF THE COMPANY'S RIGHTS OR REQUIREMENTS.
(b) To the best of your knowledge and belief all of the statements and answers on this application are true, complete and correctly stated. These statements and answers are offered to us as the basis for any policy issued on this application.
(c) Unless the policy becomes effective as specified in the Temporary Insurance Agreement attached to this application, we will incur no liability until (1) any policy applied for has been delivered to and accepted by you and (2) the first premium is paid. When you accept the policy, the state of health of the Proposed Insured and/or Applicant or any other factor affecting insurability must be the same as set forth in the application.
(d) Acceptance of the policy issued based on this application will be an acceptance of its terms and ratifications of any changes specified in the section marked "Home Office Endorsements". Any change in plan or amount of insurance, premium, classification or added benefits must be agreed to in writing.
(e) No Agent Broker or Medical Examiner can accept risks or waive any of our requirements, nor can the Agent, Broker or Medical Examiner make or alter contracts. Notice to or knowledge imputed to any Agent, Broker, Medical Examiner will not be notice to or knowledge of us unless it is set out in writing in this application.
(f) Any life insurance issued as a result of this application shall be owned by the applicant or by person(s) who receive ownership from the applicant.

Disclosures

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

Arkansas, Louisiana, Mississippi, North Carolina, South Carolina: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be subject to fines and confinement in prison.

Florida: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Georgia, Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to any insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial or insurance benefits.

I represent that copies of all sales materials and required disclosures, including Medicare disclosure have been left with the Proposed Insured.

Writing Agent

X _____
Agent LICOA Agent's No.

_____
Agent LICOA Agent's No.

_____
Agent LICOA Agent's No.

_____
Agent LICOA Agent's No.

AGENT'S STATEMENT: To the best of your knowledge does this insurance replace any existing insurance? ☐ Yes ☐ No
If Yes, give name of company and policy number.

APPLICATION FOR A&H INSURANCE - PART 8

DETAILS OF questions 2 - 20 answered "yes": Include question #, names and addresses of physicians and individuals to who history pertains.

If additional details, use a separate sheet of paper. Signed and dated by the Insured.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Life Insurance Company of Alabama. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X _____
Agent Signature LICOA Agent's No.

This Notice is to be detached, read, and retained by the Proposed Insured

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

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Accident and Disability Coverage

Important Notice to Persons on Medicare This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays: hospital or medical expenses up to the maximum stated in the policy.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include: · hospitalization · physician services · outpatient prescription drugs if you are enrolled in Medicare Part D · other approved items and services

Cut along dotted line.

Cancer and/or Heart Coverage

Important Notice to Persons on Medicare This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include: · hospitalization · physician services · hospice · outpatient prescription drugs if you are enrolled in Medicare Part D · other approved items and services

Cut along dotted line.

Intensive Care Coverage

Important Notice to Persons on Medicare This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when: · any expenses or services covered by the policy are also covered by Medicare; or · it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include: · hospitalization · physician services · hospice care · outpatient prescription drugs if you are enrolled in Medicare Part D · other approved items & services

Cut along dotted line.

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ **For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program SHIP.**

Cut along dotted line.

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

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✓ **For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program SHIP.**

Cut along dotted line.

AUTHORIZATION TO HONOR CHECKS DRAWN BY AND PAYABLE TO THE LIFE INSURANCE COMPANY OF ALABAMA, GADSDEN, ALABAMA

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks drawn by and payable to the order of the Life Insurance Company of Alabama, Gadsden, Alabama provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of The Life Insurance Company of Alabama to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Name of financial institution_____ City_____ State_____

I would like the payment withdrawn on the_____ (select the 1st through the 28th) day of the month.

Checking account no. _____ OR Savings account no._____

Signature as it appears on bank records (do not print) **X**_____

BILLING DATA AND PAYROLL DEDUCTION AUTHORIZATION

PART I - REQUIRED ON EACH SALARY SAVINGS POLICY (*PLEASE PRINT OR TYPE*)

EFFECTIVE DATE	NAME OF EMPLOYEE	SOCIAL SECURITY NO.
DEPT. NO.	NAME OF EMPLOYER	MONTHLY PREMIUM
EMP. NO.	INDICATE TYPE OF COVERAGE	WEEKLY PREMIUM

PART II - REQUIRED IF A PREMIUM IS TO BE PAID BY EMPLOYEE

I hereby request and authorize you to deduct the premium from my wage and to transmit it to Life Insurance Company of Alabama (LICOA). These deductions are to cover the premiums on the insurance policy I have applied for if the policy is issued by LICOA.

I acknowledge that this authorization is being signed at the same time I am applying for insurance coverage with LICOA, but IN NO EVENT WILL ANY INSURANCE BE IN FORCE UNTIL THE EFFECTIVE DATE OF ANY POLICY WHICH MAY BE ISSUED BY LICOA. This authorization also allows you to increase my deduction for any premium increases on the policy which may be made by LICOA.

_____ **X** _____

DATE SIGNATURE OF EMPLOYEE

Cut along dotted line.

This Notice is to be detached, read, and retained by the Proposed Insured

FAIR CREDIT REPORT ACT NOTICE

Under Public Law 91-508, we are required to inform persons proposed for insurance that, as part of our regular underwriting procedure, an investigative consumer report may be obtained, which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with your friends, neighbors, and associates. Upon written request to the Manager-Individual Policy Department at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, Alabama 35902, further information on the nature and scope of the report will be provided. **You or any person authorized to act on your behalf are entitled to receive a copy of this Authorization Form.**

To: The Bank named on the reverse side.

The Life Insurance Company of Alabama agrees:

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
(2) In the event that any such check, draft or order shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

THE LIFE INSURANCE COMPANY OF ALABAMA, Gadsden, Alabama

Clarence W. Daugette Jr.
President

Authorized in resolution adopted by the Executive Board of
The Life Insurance Company of Alabama on April 29, 1974

MEDICAL INFORMATION BUREAU, INC. (MIB), NOTICE Information regarding your insurability will be treated as confidential. We or our Reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. We or our reinsurers may release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com. The purpose of the bureau is to protect its members and their policyholders from the extra expense created by those who omit or conceal information relevant to their insurability. Information furnished by the Bureau may serve to alert the company to a need for further investigation but under Bureau rules cannot be used either wholly or partly as the basis for increasing the charge for or denying the issuance of insurance. Information in the Bureau gives no indication regarding the action taken on an application (i.e., whether accepted standard, accepted with increased premium, or declined).

APPLICATION FOR LIFE INSURANCE - PART 1

Please Use Dark Ink Suitable for Photocopying.

Life Insurance Company of Alabama

P. O. Box 349 • Gadsden, Alabama 35902

Proposed Insured

1. NAME (Last, Suffix, First, M.I.) _____

BIRTHDATE ___/___/___ STATE OF BIRTH ___ SSN# ___-___-___

HEIGHT ___' ___" WEIGHT ___ MALE ☐ FEMALE ☐ _____ Driver License # ___ ISSUE STATE

ADDRESS _____

CITY _____ STATE ___ ZIP ___

EMAIL _____

PHONE ___-___-___ PHONE #2 ___-___-___

INSURED'S EMPLOYER _____ EMPLOYMENT DATE ___/___/___

OCCUPATION _____
Describe and give exact duties

1a. Have you used tobacco in any form within the last 24 months? Yes ☐ No ☐ **1b. Citizen of U.S.A?** Yes ☐ No ☐

Coverage Type

	FACE AMOUNT	MODE PREMIUM
☐ QUICK ISSUE WHOLE LIFE ☐ E-Z Underwriting (Subject to Question 10 and Company Participation requirements)	$ ___,___	$ ___,___.___
☐ QUICK ISSUE LEVEL TERM ☐ 10 yr. ☐ 15 yr. ☐ 20 yr. ☐ 30 yr.	$ ___,___	$ ___,___.___
☐ ACCIDENTAL DEATH BENEFIT	$ ___,___	$ ___,___.___
☐ CHILDRENS TERM ___ UNITS 15 units maximum per family		$ ___,___.___
☐ WAIVER OF PREMIUM		$ ___,___.___
☐ AUTOMATIC PREMIUM LOAN Yes ☐ No ☐ Whole Life Only	TOTAL MODE PREMIUM	$ ___,___.___

Ownership

2. OWNER if other than PROPOSED INSURED

Name _____ *Relationship to Insured* _____

Street _____ Owner's SSN# or TAX ID# ___-___-___

City _____ *State* ____ *ZIP* _____

Proposed Insured becomes owner: ☐ At age of majority ☐ At owner's death ☐ When specified in writing by owner

Children's Term

3. NAME Proposed Legal Children	DATE OF BIRTH Mo.	Day	Yr.	STATE OF BIRTH	GENDER (M / F)	SOCIAL SECURITY NUMBER	HEIGHT (FT. IN.)	(LBS.) WEIGHT

If additional children, use a separate sheet of paper. Signed and dated by the Insured.

APPLICATION FOR LIFE INSURANCE - PART 2

Spouse

1. NAME (Last, Suffix, First, M.I.) _____

BIRTHDATE ☐☐/☐☐/☐☐☐☐ STATE OF BIRTH ☐☐ SSN# ☐☐☐-☐☐-☐☐☐☐

HEIGHT ☐'☐☐" WEIGHT ☐☐☐ MALE ☐ FEMALE ☐ _____ Driver License # ☐☐ ISSUE STATE

ADDRESS _____

CITY _____ STATE ☐☐ ZIP ☐☐☐☐☐

EMAIL _____

PHONE ☐☐☐-☐☐☐-☐☐☐☐ PHONE #2 ☐☐☐-☐☐☐-☐☐☐☐

INSURED'S EMPLOYER _____ EMPLOYMENT DATE ☐☐/☐☐/☐☐☐☐

OCCUPATION _____
Describe and give exact duties

1. Have you used tobacco in any form within the last 24 months? Yes ☐ No ☐ **1a. Citizen of U.S.A?** Yes ☐ No ☐

Coverage Type

	FACE AMOUNT	MODE PREMIUM
☐ QUICK ISSUE WHOLE LIFE	$ ☐☐☐,☐☐☐	$ ☐,☐☐☐.☐☐
☐ QUICK ISSUE LEVEL TERM ☐ 10 yr. ☐ 15 yr. ☐ 20 yr. ☐ 30 yr.	$ ☐☐☐,☐☐☐	$ ☐,☐☐☐.☐☐
☐ ACCIDENTAL DEATH BENEFIT	$ ☐☐☐,☐☐☐	$ ☐,☐☐☐.☐☐
☐ CHILDRENS TERM ☐☐ UNITS 15 units maximum per family		$ ☐,☐☐☐.☐☐
☐ WAIVER OF PREMIUM		$ ☐,☐☐☐.☐☐
☐ AUTOMATIC PREMIUM LOAN Whole Life Only Yes ☐ No ☐	TOTAL MODE PREMIUM	$ ☐,☐☐☐.☐☐

Ownership

2. OWNER if other than PROPOSED INSURED

Name _____

Street _____

City _____ *State*____ *ZIP*_____

Relationship to Insured _____

Owner's SSN# or TAX ID# ☐☐☐-☐☐-☐☐☐☐

Proposed Insured becomes owner: ☐ At age of majority ☐ At owner's death ☐ When specified in writing by owner

Children's Term

3. NAME Proposed Legal Children	DATE OF BIRTH Mo.	Day	Yr.	STATE OF BIRTH	GENDER (M / F)	SOCIAL SECURITY NUMBER	HEIGHT (FT. IN.)	(LBS.) WEIGHT

If additional children, use a separate sheet of paper. Signed and dated by the Insured.

Payment Info. Insured

If Bank Draft Payment is chosen, complete Authorization to Honor Checks

7. PAYMENT MODE *(Monthly Direct Bill Not Available)*

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

☐ Bank Draft ☐ Payroll Deduction ☐ Direct Bill

☐ Payment with app $_____ ☐ Draft first payment

Additional details_____

BILLING ADDRESS INFORMATION

☐ Proposed Insured's address ☐ Primary Owner's address

☐ Other Premium Payor's / Alternate billing address *(details below)*

Name _____

Street _____

City _____ *State*____ *ZIP*_____

☐ *Special arrangements* _____

Payment Info. Spouse

If Bank Draft Payment is chosen, complete Authorization to Honor Checks

7a. PAYMENT MODE *(Monthly Direct Bill Not Available)*

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

☐ Bank Draft ☐ Payroll Deduction ☐ Direct Bill

☐ Payment with app $_____ ☐ Draft first payment

Additional details_____

BILLING ADDRESS INFORMATION

☐ Spouse's address ☐ Primary Owner's address

☐ Other Premium Payor's / Alternate billing address *(details below)*

Name _____

Street _____

City _____ *State*____ *ZIP*_____

☐ *Special arrangements* _____

Existing Insurance

8. EXISTING or APPLIED FOR INSURANCE

Does any Proposed Insured have any existing life insurance or annuity contracts in force or applications pending? Yes ☐ No ☐

If YES, complete and submit attached replacement forms with this application and list all in force and pending life insurance coverage below.

Insured's Name	Company	Owner	Replacement	Life Amount	Accidental Death Benefit	Year Issued
			Yes ☐ No ☐			
			Yes ☐ No ☐			
			Yes ☐ No ☐			
			Yes ☐ No ☐			

Beneficiary Designation

9.	Name and Address	Relationship		%
Insured			Primary	
Insured			Contingent	
Spouse			Primary	
Spouse			Contingent	

If additional beneficiaries, use a separate sheet of paper. Signed and dated by the Insured.

MEDICAL QUESTIONS - PART 4

	PROPOSED INSURED		SPOUSE		CHILDREN TERM RIDER	
	Yes	No	Yes	No	Yes	No
10. IS ANY PERSON PROPOSED FOR INSURANCE currently in the hospital or receiving disability payments; or, in the past 5 years has any proposed insured been treated by a licensed member of the medical profession for a heart attack, stroke, internal cancer, melanoma, disease or disorder of the lungs, hepatitis, tested positive for exposure to Human Immunodeficiency Virus (HIV) infection or been diagnosed as having Aids Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the Human Immunodeficiency Virus (HIV) infection or other sickness or condition derived from such infection?	☐	☐	☐	☐	☐	☐
11. HAS ANY PERSON proposed for insurance in Part 1 and Part 2:						
(a) Used marijuana, narcotic, hallucinogenic or habit forming drugs not prescribed by a physician?	☐	☐	☐	☐	☐	☐
(b) Had any motor vehicle moving violations or accidents within the last two years?	☐	☐	☐	☐	☐	☐
(c) Been arrested for any reason other than moving traffic violations?	☐	☐	☐	☐	☐	☐
(d) Flown other than as a fare-paying passenger within the last two years or considering such flying in the next two (2) years? *(If yes, complete Aviation Questionnaire.)*	☐	☐	☐	☐	☐	☐
(e) Any past, present or expected (in the next two (2) years) activity in racing, skin or sky diving, bungee jumping, base jumping, parasailing, rock climbing, hang gliding or ultra-light flying? *(If yes, complete Hazardous Sports Questionnaire.)*	☐	☐	☐	☐	☐	☐
(f) Ever had an application for insurance or reinstatement of insurance declined, postponed, rated up or modified?	☐	☐	☐	☐	☐	☐
12. IN THE LAST 10 YEARS, HAS ANY PERSON proposed for insurance in Part 1 and Part 2 ever been treated by a licensed member of the medical profession for:						
(a) Heart attack, chest pain, heart murmur, high blood pressure or any other disease of the heart, blood, arteries or blood vessels?	☐	☐	☐	☐	☐	☐
(b) Peptic ulcer, Ulcerative Colitis, Crohn's disease or any disease of the esophagus, stomach, intestines, pancreas or liver?	☐	☐	☐	☐	☐	☐
(c) Emphysema, bronchitis, asthma, Chronic Obstructive Pulmonary Disease (COPD) or any disease of the lungs or respiratory system?	☐	☐	☐	☐	☐	☐
(d) Hepatitis, diabetes, albumin, pus, blood or sugar in urine, venereal disease or any other disease of the kidneys, bladder, gland, reproductive organs or connective tissue disorder?	☐	☐	☐	☐	☐	☐
(e) Stroke, transient ischemic attack (TIA), severe headaches, fainting spells, epilepsy, paralysis, nervousness, mental disorder or any other disease of the brain, nervous system or been treated for a back condition?	☐	☐	☐	☐	☐	☐
(f) Any disease or disorder of the eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐
(g) Tested positive for exposure to Human Immunodeficiency Virus (HIV) infection or been diagnosed as having Aids Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the Human Immunodeficiency Virus (HIV) infection or other sickness or condition derived from such infection?	☐	☐	☐	☐	☐	☐
(h) Alcohol or drug abuse?	☐	☐	☐	☐	☐	☐
(i) Any cancer or tumor including cancer of the bone marrow, blood, lymph nodes, carcinoma-in-situ, skin cancer or melanoma?	☐	☐	☐	☐	☐	☐
(j) Any abnormality, deformity, disease, illness, injury or disorder not mentioned above?	☐	☐	☐	☐	☐	☐
13. OTHER THAN INDICATED ABOVE, has any person proposed for insurance in Part 1 and Part 2:	Yes	No	Yes	No	Yes	No
(a) Ever applied for or received a pension or disability benefit?	☐	☐	☐	☐	☐	☐
(b) Been hospitalized in the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(c) Consulted a physician during the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(d) Had a change of weight in the past year?	☐	☐	☐	☐	☐	☐
(e) Had an immediate family member (Father, Mother, Brothers or Sisters) with a history of diabetes, mental, nervous, heart or circulatory disorder, tuberculosis, cancer, high blood pressure, kidney disease or suicide? In Details section below, include age(s) at diagnosis, condition, relationship, age(s) if living, age(s) at death and cause of death.	☐	☐	☐	☐	☐	☐
14. IN THE LAST 24 MONTHS, has any person proposed for insurance in Part 1 & Part 2 been under observation or treatment of a physician or had or been advised to have any diagnostic test, procedure, screening, surgery or awaiting test results? If yes, please provide details including date(s), reason(s) and result(s).	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐
15. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please indicate if Retired or active: list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the space provided below for "Details".)*	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐

DETAILS OF questions 10 - 15 answered "yes": Include question #, names and addresses of physicians and individuals to whom the history pertains.

If additional details, use a separate sheet of paper. Signed and dated by the Insured.

AGREEMENT **Terms used In this Agreement:**
"You" and "Your" mean the Proposed Insured and the Applicant, if other than the Proposed Insured. "We", "us" and "our" mean the Life Insurance Company of Alabama. It is understood and agreed by you that:
(a) Any policy issued as a result of this application shall constitute a single and entire contract of insurance. Only the President, a Vice President, the Secretary or an Assistant Secretary of the Company may make a contract on its behalf. No waiver or modification of a contract provision or any of the Company's rights or requirements shall be binding upon the Company unless it is in writing signed by one of such officers. NEITHER THE AGENT WHOSE SIGNATURE APPEARS BELOW, NOR ANY OTHER AGENT OR BROKER, NOR ANY MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS, PASS UPON INSURABILITY, MAKE OR MODIFY CONTRACTS OR WAIVE ANY OF THE COMPANY'S RIGHTS OR REQUIREMENTS.
(b) To the best of your knowledge and belief all of the statements and answers on this application are true, complete and correctly stated. These statements and answers are offered to us as the basis for any policy issued on this application.
(c) Unless the policy becomes effective as specified in the Temporary Insurance Agreement attached to this application, we will incur no liability until (1) any policy applied for has been delivered to and accepted by you and (2) the first premium is paid. When you accept the policy, the state of health of the Proposed Insured and/or Applicant or any other factor affecting insurability must be the same as set forth in the application.
(d) Acceptance of the policy issued based on this application will be an acceptance of its terms and ratifications of any changes specified in the section marked "Home Office Endorsements". Any change in plan or amount of insurance, premium, classification or added benefits must be agreed to in writing.
(e) No Agent Broker or Medical Examiner can accept risks or waive any of our requirements, nor can the Agent, Broker or Medical Examiner make or alter contracts. Notice to or knowledge imputed to any Agent, Broker, Medical Examiner will not be notice to or knowledge of us unless it is set out in writing in this application.
(f) Any life insurance issued as a result of this application shall be owned by the applicant or by person(s) who receive ownership from the applicant.

Disclosures

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

Arkansas, Louisiana, Mississippi, North Carolina, South Carolina: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be subject to fines and confinement in prison.

Florida: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Georgia, Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to any insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial or insurance benefits.

I represent that copies of all sales material have been left with the Proposed Insured.

Writing Agent

X _____
Agent LICOA Agent's No.

_____
Agent LICOA Agent's No.

_____
Agent LICOA Agent's No.

_____
Agent LICOA Agent's No.

AGENT'S STATEMENT: To the best of your knowledge does this insurance replace any existing insurance? ☐ Yes ☐ No
If Yes, give name of company and policy number.

AGENT'S STATEMENT: Was the Temporary Life Insurance Agreement left with the owner? ☐ Yes ☐ No

APPLICATION FOR LIFE INSURANCE - PART 6

Please provide name of doctor, practitioner, or health care facility who can provide the most complete and up-to-date information concerning any health condition listed on Part 4 of this application for any Proposed Insured.

Physician Information

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ___ - ___ - ____

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ___ - ___ - ____

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ___ - ___ - ____

AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION I hereby authorize the above person(s) or entity(s) listed in above and MIB, Inc. and any prescription drug or pharmacy organization(s) to provide **Life Insurance Company of Alabama,** or its reinsurers, or to **Lab One/Exam One** on the behalf of Life Insurance Company of Alabama, information, data, or records concerning advice, care, treatment or health history provided to the person(s) named above, including, but not limited to, notes, reports, test results, x-rays, documents related to any mental conditions, cost of medical services, prognosis, physician notes of patient interviews, patient notes, pharmacy records or other data and including the full and complete clinical records, hospital charts, examination records and medical history I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol program; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition; information relating to HIV testing, HIV status, or AIDS. I understand that such information may be subject to special protections pursuant to law and that by signing this authorization. I authorize the person(s) or entity(s) listed to disclose records containing such information. Please list any special instructions. I authorize Life Insurance Company of Alabama, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.. I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at: *Life Insurance Company of Alabama, Attn: Privacy Official, PO Box 349, Gadsden, AL 35902*. I understand that the revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when my insurance coverage ends (twenty-four (24) months from the date shown below in Kentucky and Oklahoma, thirty (30) months from the date shown below in Georgia and North Carolina), if not revoked before such date. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that this authorization is needed for the purpose of gathering information for making eligibility, underwriting and risk rating determinations.

BY THE SIGNATURE(s) below I (we) do attest that the statements and answers in all parts of this application are complete and true and will be the basis for any insurance issued.

As normal procedure, the Home Office Underwriting Department may contact you by telephone to verify pertinent information contained in your application.

HOME OFFICE ENDORSEMENTS:

Signed at_____
City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Owner or Applicant if other than Proposed Insured

X_____
Signature of Spouse

X_____
Signature of Owner or Applicant if other than Spouse

Temporary Life Insurance Agreement and Receipt

A copy of this Agreement is to be left with the owner if all questions are answered 'No' and pre-condition 2 is met. Second copy is sent with the Application.

Do not leave a copy of this Agreement or accept a payment if a question has a 'Yes" answer.

Instead, check "No" on the next page, page 8, and obtain the owner's initials under the acknowledgement section.

Definitions

For purposes of this Temporary Life Insurance Agreement ("Agreement"): "Application" means the Application for Individual Life Insurance from which this Agreement is to be and was physically detached and provided to the owner. "Agent" means the licensed individual who signed this Application as the Agent. "Proposed insured" means the person identified as the proposed life insured, and the person identified as the Spouse life insured, if any, in the Application. "Owner" is identified in the 'Information about the Owner' section of the Application.

Pre-Conditions to Temporary Coverage

Subject to the terms of this Agreement, Life of Alabama agrees to provide the temporary coverage set out in this Agreement if each of the following pre-conditions are met:

1. All questions in this Agreement are answered 'No' and the 'No' answers shown to the questions in this Agreement are truthful.
2. No later than the date of signing this Application, an amount equal to at least a monthly premium for the insurance applied for in the Application was given to the Agent or arrangements have been made for the insurance premium to be payroll deducted through the proposed insured's employer.

If either of the above pre-conditions are not met, no temporary coverage takes effect under this Agreement even if the Agreement was left with the owner.

Temporary Life Insurance Agreement Questions

	Proposed Insured	Spouse
1. Within the past 12 months, has there been either an investigation or treatment, or both, by a physician or medical practitioner for chest pain, heart-related illness, stroke or cancer?	☐ Yes ☐ No	☐ Yes ☐ No
2. Within the past 90 days, been admitted for more than 2 consecutive days to a hospital (other than for childbirth)?	☐ Yes ☐ No	☐ Yes ☐ No
3. Within the past 90 days, has a licensed medical professional recommended a medical test, investigation or surgery, or combination thereof, which was refused to be undertaken or has not yet been undertaken?	☐ Yes ☐ No	☐ Yes ☐ No

Amount given to Agent is $_____ ☐ No amount given to Agent.

Amount of Temporary Coverage

Subject to the terms of this Agreement, if all of the above pre-conditions are met and a proposed insured dies while this Agreement is in effect, Life of Alabama shall pay under this and all other Life of Alabama temporary life insurance agreement(s), to the beneficiary(ies), as shown in the Application, for that proposed insured, the lesser of:

1. The amount of insurance applied for in the Application on the life of that deceased proposed insured, including the amount payable for the death of that proposed insured under a rider applied for; or
2. $100,000.

Termination of Temporary Coverage

Subject to the terms of this Agreement, if temporary coverage takes effect under this Agreement, temporary coverage will terminate, and shall be of no further in force or effect, on the earliest of the following:

1. Sixty (60) days from the date shown in the Application as the date that the Application was signed by the owner. That date shall be the first day for purposes of calculating this sixty (60) day period.
2. The date an approved Life of Alabama policy on the life of a proposed insured takes effect as described in that policy, if a policy is issued in response to the Application.
3. The date Life of Alabama offers, as shown in Life of Alabama's records, the owner a Life of Alabama policy in response to, but not as applied for in, the Application.
4. The date a written or oral request to withdraw the Application is made by or on behalf of a proposed insured or the owner.
5. The date a written or oral request to terminate this Agreement is made by or on behalf of a proposed insured or the owner.
6. The date written notice is sent by Life of Alabama, as shown in Life of Alabama's records, to a proposed insured or the owner, terminating this Agreement.
7. The date written notice is sent by Life of Alabama, as shown in Life of Alabama's records, to the proposed insured or the owner, declining the Application.

Special Limitations

1. Fraud, material misrepresentation or non-disclosure in the Application will void this Agreement and limit Life of Alabama's liability to a refund of payment(s) made to Life of Alabama.
2. This Agreement shall be void if a check or draft given to the Agent is not honored when presented for payment.
3. If a proposed insured dies by suicide, whether sane or insane, Life of Alabama's liability under this Agreement is limited to a refund of the payment(s) made to Life of Alabama.
4. No temporary coverage will be provided under this Agreement to a proposed insured whose age is 66 or older on the date the Application is signed by the owner.

Payment to Life of Alabama

A check given to the Agent must be made payable to Life of Alabama. Do not make check payable to the Agent or leave the payee blank.

Entire Agreement

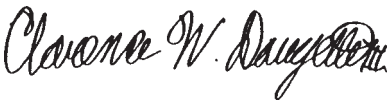
This Agreement contains the entire terms regarding temporary coverage. No one, including the Agent signing in the signature section of the Application, is authorized to waive, modify or change in writing, orally, or otherwise the terms of this Agreement or to promise or represent the terms of this Agreement other than as expressly written in this Agreement.

Governing Law

This Agreement shall be governed by and subject to the laws of the State in which this Agreement was delivered to the owner.

I, a proposed insured and/or the owner, by signing in the signature section of this Application, acknowledge and agree that I have reviewed, understand, and accept the terms of this Temporary Life Insurance Agreement, including the pre-conditions and special limitations to temporary coverage and the amount and termination of temporary coverage.

Countersigned



Clarence W. Daugette, III
President

Temporary Life Insurance Agreement Acknowledgement

Was this Temporary Life Insurance Agreement left with the owner? ☐Yes ☐No
If No, owner acknowledges that there is no temporary life insurance coverage in effect _____
(owner's initials)

X _____
Agent Signature LICOA Agent's No.

Signed at_____
City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Owner or Applicant if other than proposed insured

X_____
Signature of Spouse

X_____
Signature of Owner or Applicant if other than spouse

Temporary Life Insurance Agreement and Receipt

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2. Within the past 90 days, been admitted for more than 2 consecutive days to a hospital (other than for childbirth)?	☐ Yes ☐ No	☐ Yes ☐ No
3. Within the past 90 days, has a licensed medical professional recommended a medical test, investigation or surgery, or combination thereof, which was refused to be undertaken or has not yet been undertaken?	☐ Yes ☐ No	☐ Yes ☐ No

Amount given to Agent is $_____ ☐ No amount given to Agent.

Amount of Temporary Coverage

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3. The date Life of Alabama offers, as shown in Life of Alabama's records, the owner a Life of Alabama policy in response to, but not as applied for in, the Application.
4. The date a written or oral request to withdraw the Application is made by or on behalf of a proposed insured or the owner.
5. The date a written or oral request to terminate this Agreement is made by or on behalf of a proposed insured or the owner.
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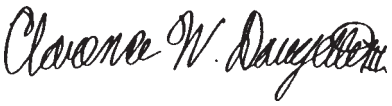
Governing Law

This Agreement shall be governed by and subject to the laws of the State in which this Agreement was delivered to the owner.

I, a proposed insured and/or the owner, by signing in the signature section of this Application, acknowledge and agree that I have reviewed, understand, and accept the terms of this Temporary Life Insurance Agreement, including the pre-conditions and special limitations to temporary coverage and the amount and termination of temporary coverage.

Countersigned



Clarence W. Daugette, III
President

Temporary Life Insurance Agreement Acknowledgement

Was this Temporary Life Insurance Agreement left with the owner? ☐Yes ☐No
If No, owner acknowledges that there is no temporary life insurance coverage in effect _____
(owner's initials)

X _____
Agent Signature LICOA Agent's No.

Signed at _____
City State

Date _____
Month Day Year

X _____
Signature of Proposed Insured

X _____
Signature of Owner or Applicant if other than proposed insured

X _____
Signature of Spouse

X _____
Signature of Owner or Applicant if other than spouse

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

A copy of this Agreement is to be left with the applicant. Second copy is sent with the Application.

If the applicant has an existing policy or contract, the agent or broker who initiated the application must present and read to the applicant, no later than at the time of taking the application, a completed and signed copy of the "Notice Regarding Replacement". The following procedures apply even if there is no intention to replace an existing policy or contract:

The notice must be signed by both the applicant and agent attesting that the notice has been read aloud by the agent or that the applicant did not wish the notice to be read aloud and that a copy of the notice was left with the applicant.

This notice must be completed by listing all policies or annuities proposed to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number, if available, or alternative identification such as an application or receipt number. Also, the list shall include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for a new policy.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐YES ☐ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐YES ☐ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY NUMBER	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because

_____.

I attest that the responses herein are, to the best of my knowledge, accurate:

Signed at_____
City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Owner or Applicant if other than proposed insured

X_____
Signature of Spouse

X_____
Signature of Owner or Applicant if other than spouse

X _____
Agent Signature LICOA Agent's No.

I do not want this notice read aloud to me. ____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS: Are they affordable?
Could they change?
You're older—are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES: New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?

INSURABILITY: If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
How are premiums for both policies being paid?
How will the premiums on your existing policy be affected? Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

A copy of this Agreement is to be left with the applicant. Second copy is sent with the Application.

If the applicant has an existing policy or contract, the agent or broker who initiated the application must present and read to the applicant, no later than at the time of taking the application, a completed and signed copy of the "Notice Regarding Replacement". The following procedures apply even if there is no intention to replace an existing policy or contract:

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This notice must be completed by listing all policies or annuities proposed to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number, if available, or alternative identification such as an application or receipt number. Also, the list shall include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for a new policy.

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A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐YES ☐ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐YES ☐ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY NUMBER	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

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I attest that the responses herein are, to the best of my knowledge, accurate:

Signed at_____
City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Owner or Applicant if other than proposed insured

X_____
Signature of Spouse

X_____
Signature of Owner or Applicant if other than spouse

X _____
Agent Signature LICOA Agent's No.

I do not want this notice read aloud to me. ____ (Applicants must initial only if they do not want the notice read aloud.)

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OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

AUTHORIZATION TO HONOR CHECKS DRAWN BY AND PAYABLE TO THE LIFE INSURANCE COMPANY OF ALABAMA, GADSDEN, ALABAMA

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks drawn by and payable to the order of the Life Insurance Company of Alabama, Gadsden, Alabama provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of The Life Insurance Company of Alabama to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Name of financial institution_____ City_____ State_____

I would like the payment withdrawn on the_____ (select the 1st through the 28th) day of the month.

Checking account no. _____ OR Savings account no._____

Signature as it appears on bank records (do not print) **X**_____

AUTHORIZATION TO HONOR CHECKS DRAWN BY AND PAYABLE TO THE LIFE INSURANCE COMPANY OF ALABAMA, GADSDEN, ALABAMA

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks drawn by and payable to the order of the Life Insurance Company of Alabama, Gadsden, Alabama provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of The Life Insurance Company of Alabama to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Name of financial institution_____ City_____ State_____

I would like the payment withdrawn on the_____ (select the 1st through the 28th) day of the month.

Checking account no. _____ OR Savings account no._____

Signature as it appears on bank records (do not print) **X**_____

BILLING DATA AND PAYROLL DEDUCTION AUTHORIZATION

PART I - REQUIRED ON EACH SALARY SAVINGS POLICY (***PLEASE PRINT OR TYPE***)

EFFECTIVE DATE	NAME OF EMPLOYEE	SOCIAL SECURITY NO.
DEPT. NO.	NAME OF EMPLOYER	MONTHLY PREMIUM
EMP. NO.	INDICATE TYPE OF COVERAGE	WEEKLY PREMIUM

PART II - REQUIRED IF A PREMIUM IS TO BE PAID BY EMPLOYEE

I hereby request and authorize you to deduct the premium from my wage and to transmit it to Life Insurance Company of Alabama (LICOA). These deductions are to cover the premiums on the insurance policy I have applied for if the policy is issued by LICOA.

I acknowledge that this authorization is being signed at the same time I am applying for insurance coverage with LICOA, but IN NO EVENT WILL ANY INSURANCE BE IN FORCE UNTIL THE EFFECTIVE DATE OF ANY POLICY WHICH MAY BE ISSUED BY LICOA. This authorization also allows you to increase my deduction for any premium increases on the policy which may be made by LICOA.

_____ **X** _____

DATE SIGNATURE OF EMPLOYEE

Cut along dotted line.

This Notice is to be detached, read, and retained by the Proposed Insured

FAIR CREDIT REPORT ACT NOTICE

Under Public Law 91-508, we are required to inform persons proposed for insurance that, as part of our regular underwriting procedure, an investigative consumer report may be obtained, which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with your friends, neighbors, and associates. Upon written request to the Manager-Individual Policy Department at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, Alabama 35902, further information on the nature and scope of the report will be provided. **You or any person authorized to act on your behalf are entitled to receive a copy of this Authorization Form.**

To: The Bank named on the reverse side.

The Life Insurance Company of Alabama agrees:

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
(2) In the event that any such check, draft or order shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

THE LIFE INSURANCE COMPANY OF ALABAMA, Gadsden, Alabama

President

Authorized in resolution adopted by the Executive Board of
The Life Insurance Company of Alabama on April 29, 1974

To: The Bank named on the reverse side.

The Life Insurance Company of Alabama agrees:

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
(2) In the event that any such check, draft or order shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

THE LIFE INSURANCE COMPANY OF ALABAMA, Gadsden, Alabama

President

Authorized in resolution adopted by the Executive Board of
The Life Insurance Company of Alabama on April 29, 1974

MEDICAL INFORMATION BUREAU, INC. (MIB), NOTICE Information regarding your insurability will be treated as confidential. We or our Reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. We or our reinsurers may release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com. The purpose of the bureau is to protect its members and their policyholders from the extra expense created by those who omit or conceal information relevant to their insurability. Information furnished by the Bureau may serve to alert the company to a need for further investigation but under Bureau rules cannot be used either wholly or partly as the basis for increasing the charge for or denying the issuance of insurance. Information in the Bureau gives no indication regarding the action taken on an application (i.e., whether accepted standard, accepted with increased premium, or declined).

Life Insurance Company of Alabama

302 Broad Street
Gadsden, Alabama 35901
800-226-2371

CRITICAL ILLNESS BENEFIT POLICY

OUTLINE OF COVERAGE
For Policy Form Number HH892012AR

THE POLICY PROVIDES LIMITED BENEFITS

THE POLICY IS A SPECIFIED DISEASE INDEMNITY POLICY WHICH ONLY PROVIDES BENEFITS FOR CERTAIN CRITICAL ILLNESS. IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS, CONDITION OR INCAPACITY.

THIS IS A LIMITED BENEFIT POLICY – PLEASE READ YOUR POLICY CAREFULLY - This outline of coverage provides a very brief description of some of the important features of the policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and the Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

CRITICAL ILLNESS INSURANCE COVERAGE – Policies of this category are designed to provide persons insured, restricted coverage paying ONLY when certain losses occur as a certain critical illness. Coverage is not provided for basic hospital, basic medical-surgical, or major medical or comprehensive expenses.

BENEFITS

Qualifying For Benefits
We will pay the Critical Illness Benefit selected, if a Critical Illness is Incurred (or Manifests) and is Diagnosed more than 30 days after the Effective Date. Payment of the Primary Insured's Critical Illness Benefit Maximum terminates this Policy. Payment of the Critical Illness Benefit Maximum for a Covered Person terminates coverage for that Covered Person. The Critical Illness Benefit Maximum for a Covered Person is reduced by the amount of all Critical Illness Benefit amounts paid for that Covered Person. The total of all Critical Illness Benefits payments for a Covered Person cannot exceed the Critical Illness Benefit Maximum for that Covered Person as selected. No Critical Illness Benefit is payable more than once.

Critical Illness Benefit

1. The Critical Illness Benefit Maximum is reduced by the amount of all Critical Illness Benefit amounts paid.
2. The total of all Critical Illness Benefit payments cannot exceed the Critical Illness Benefit Maximum.
3. No Critical Illness Benefit is payable more than once.
4. Payment of the Critical Illness Benefit Maximum terminates the policy.
5. On a Covered Person's attained age 70, all Critical Illness Benefits and the Critical Illness Benefit Maximum, less any benefits previously paid, will be reduced by one-half (50%).

Benefit Payment Conditions

The payment of benefits for a Critical Illness is subject to the following conditions:

1. The benefit payment is not excluded by any general or specific exclusion or limitation.
2. The Critical Illness Diagnosis is made by a legally licensed Physician during the lifetime of a Covered Person and includes diagnosis after death.

Critical Illness
In the policy, the term Critical Illness means a Heart Attack, Kidney Failure, Stroke, Major Organ Transplant, Coronary Artery Angioplasty and Coronary Artery Bypass Grafting. Benefits are not provided for any other Critical Illness.

Heart Attack Benefit
We will pay the Heart Attack Benefit if a Heart Attack is Incurred, Manifested and Diagnosed more than 30 days after the Effective Date of the policy. A Heart Attack that is Incurred during or within 24 hours of any heart, cardiac or coronary artery medical procedure is excluded.

A Heart Attack means an Acute Myocardial Infarction resulting in death of heart muscle due to inadequate blood supply. . All of the following criteria for acute myocardial infarction must be satisfied:

1. Medical documentation of typical clinical symptoms, for example, central chest pain; and
2. diagnostic increase of specific cardiac markers or elevated cardiac enzymes; and
3. new electrocardiographic changes consistent with an Acute Myocardial Infarction.
4. The Critical Illness Diagnosis of an Acute Myocardial Infarction must be made by a legally licensed Physician during the Covered Person's lifetime and includes diagnosis after death.
   Heart Attack does not mean a cardiac arrest, congestive heart failure, cardiopulmonary arrest or any condition other than an Acute Myocardial Infarction.

Kidney Failure Benefit
We will pay the Kidney Failure Benefit if Kidney Failure both Manifests and is Diagnosed more than 30 days after the Effective Date of the policy.

Kidney Failure means chronic irreversible failure of both kidneys to function, as a result of which either regular renal or peritoneal dialysis, or renal transplant is initiated. The Critical Illness Diagnosis must be made by a legally licensed Physician during the Covered Person's lifetime and includes diagnosis after death.

Stroke Benefit
We will pay the Stroke Benefit if a Stroke is Incurred, Manifested and Diagnosed more than 30 days after the Effective Date of the policy.

A Stroke means death of brain tissue due to an acute cerebrovascular event. All of the following criteria for stroke must be satisfied:

1. clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage;
2. clear evidence on a CT, MRI or similar imaging technique that a stroke has occurred; and
3. permanent neurologic deficit measured 30 days or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome.
4. The Critical Illness Diagnosis must be made by a legally licensed Physician during the Covered Person's lifetime and includes diagnosis after death.

Symptoms due to and conditions of transient ischemic attack, migraine, hypoxia, traumatic injury to brain tissue or blood vessels, and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

Major Organ Transplant Benefit
We will pay the Major Organ Transplant Benefit if more than 30 days after the Effective Date of the policy both.

1. the need for a Major Organ Transplant is first Diagnosed; and
2. the Covered Person undergoes a Major Organ Transplant.

A Major Organ Transplant means human to human organ transplant from a donor to the Insured of: bone marrow (solely for treatment of cancer or bone marrow failure), or transplant of an entire kidney, liver, heart, lung, or pancreas. Transplant of any other organs, parts of organs, tissues or cells are excluded.

Coronary Artery Angioplasty Benefit
We will pay the Coronary Artery Angioplasty Benefit if more than 30 days after the Effective Date of the policy both.

1. the need for a Coronary Artery Angioplasty is first Diagnosed; and
2. the Covered Person undergoes a Coronary Artery Angioplasty.

A Coronary Artery Angioplasty means balloon angioplasty; laser angioplasty; angioplasty and stent placement; or atherectomy; to correct narrowing or blockage of one or more coronary arteries.

Coronary Artery Bypass Grafting Benefit
We will pay the Coronary Artery Bypass Grafting Benefit if more than 30 days after the Effective Date of the policy both.

1. the need for a Coronary Artery Bypass Grafting is first Diagnosed; and
2. the Covered Person undergoes a Coronary Artery Bypass Grafting.

Coronary Artery Bypass Grafting means major open heart surgery requiring median sternotomy (division of the breast bone) to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Procedures that do not require median sternotomy are excluded, including but not limited to, minimally invasive, endoscopic, and "keyhole" heart surgery; balloon and laser angioplasty; stent procedures; and atherectomy.

Important Definitions
Covered Persons are indicated by the coverage type selected:

1) Individual: Only the Primary Insured listed on the Policy Schedule Page is covered.
2) Individual and Spouse: The Primary Insured and the Primary Insured's Legal Spouse as listed on the application or added/changed by endorsement are covered.
3) One Parent Family: The Primary Insured and all of the Primary Insured's legal Dependent Child(ren) as listed on the application or added/changed by endorsement are covered.
4) Two Parent Family: The Primary Insured, The Primary Insured's Legal Spouse as listed on the application or added/changed by endorsement and all of the Primary Insured's legal Dependent Child(ren) as listed on the application or added/changed by endorsement are covered.

Any person specifically excluded by name from coverage is NOT included as a Covered Person.

Critical Illness Benefit Maximum means the maximum total dollar amount payable under the policy. The Critical Illness Benefit Maximum is reduced, for all Covered Persons, by fifty percent (50%) on the Covered Person's attained age of 70 years.

Diagnosed or Diagnosis means a definitive identification of the Critical Illness made by a Physician (where applicable, specializing in a particular area of medicine) and supported by documentation of all appropriate and defined studies:

1. based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
2. meets any diagnostic requirements stated in the policy for the particular Critical Illness being diagnosed; and
3. performed during the lifetime of the Covered Person and includes diagnosis after death.

Effective Date means the date that the policy becomes effective.

Incur or Incurred means an event, incident, or condition that:

1. occurs on or after the Effective Date of the policy, and
2. occurs while the policy is in force, and
3. is Diagnosed during the life of the Covered Person and includes diagnosis after death and
4. is not specifically excluded by any definitions or exclusions in the policy.

Manifests or Manifested means a condition or symptom that would cause an ordinary prudent person to seek medical advice, care, or treatment.

Physician means a person who:

1. is a legally qualified medical practitioner in good standing and a Doctorate of the healing arts licensed in the United States or its territories; and
2. practices within the scope of his or her license and specialty in the United States or its territories; and
3. is not the Covered Person; or
4. is not the Covered Person's immediate family member or business associate; or
5. does not customarily reside in the same household as the Covered Person.

A Physician does NOT mean an emergency medical technician, nurse, nurse practitioner, physician's assistant, coroner or other medical personnel that does not meet the above qualifications.

Exclusions and Limitations

We will not pay benefits for a loss while being, caused by, contributed to, or resulting from:

- Any act of war, declared or undeclared, or
- Active duty in the armed forces, National Guard, or any reserve unit, or
- Engaging in a felony, or participating in any riot or civil insurrection; or
- Engaging in an illegal activity; or participating in any riot or civil insurrection; or
- Any intentionally self-inflicted injury; suicide, or suicide attempt, or
- Under the influence of alcohol (including the operation of or passenger of a motor vehicle with a blood alcohol concentration in excess of the legal limit of the state in which the accident occurs) or a controlled substance unless legally prescribed and used in the manner consistent with that prescription; or
- Any benefits for conditions diagnosed outside of the United States unless the Diagnosis and Date of Diagnosis can be confirmed in the United States by a Physician; or
- Any illness, loss, or condition specifically excluded from the definition of any Critical Illness
- Any illness, loss, or condition not stated as a covered Critical Illness in the policy.
- Any Critical Illness in which ALL of the criteria and Proof of Loss has not been received by the Company.

Renewability

You may continue the coverage provided by the policy by paying all premiums when due, until the policy anniversary on or following the expiry date, subject to the policy's termination provision.

Premium.

We reserve the right to change the premium rates for the policy. Any change in premium will be made on a premium class basis. No change in premium will become effective until 40 days after a notification is sent to your last known address, on Our Home Office Records.

Benefit Amount Selections		**Premium**
Critical Illness Base Plan		**$** _____
Critical Illness Maximum Benefit Amount		
Heart Attack Benefit	_____	
Kidney Failure Benefit	_____	
Stroke Benefit	_____	
Major Organ Transplant Benefit	_____	
Coronary Artery Angioplasty Benefit	_____	
Coronary Artery Bypass Grafting	_____	
Optional Riders		
☐ **Wellness Rider**		**$** _____
	Total Premium	**$** _____

LICOA
Life Insurance Company of Alabama
HOME OFFICE • GADSDEN, ALABAMA 35902

Protecting your financial security

CRITICAL ILLNESS BENEFIT POLICY

LIFE INSURANCE COMPANY OF ALABAMA agrees to pay the benefits according to the provisions of this Policy. All benefits are subject to its provisions, exclusions and limitations. This Policy is a legal contract between You and Us.

Signed for the Company at Gadsden, Alabama.

Secretary President

CONSIDERATION

This Policy is issued to You in consideration of Your application and the receipt of the first premium. This Policy is a legal contract between You and Us. Your Policy is effective at 12:01 a.m. on the Effective Date in the time zone of Your home address as indicated on the Policy Schedule page.

NOTICE OF RIGHT TO EXAMINE POLICY

You should read this entire contract carefully and refer to the DEFINITIONS section to understand the meaning of defined words. The application and any amendments or riders are a part of this contract. You must review and give special attention to make sure all of the information in the application and amendments are accurate and complete. You notify Us of any information that is inaccurate, incomplete or omitted within thirty (30) days after delivery of this Policy. You may return this Policy within thirty (30) days after the delivery if You are not satisfied with it for any reason to: Life Insurance Company of Alabama, PO Box 349, Gadsden, AL 35902. The return of this Policy will void it from the Effective Date and any premium We receive will be refunded.

GUARANTEED RENEWABLE TO AGE 90
SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS BY CLASS

You may continue the coverage provided by this Policy by paying all premiums when due, until the Policy anniversary on or following the Expiry Date, subject to the Policy's Termination provision. We reserve the right to change the premium rates for this Policy. Any change in premium will be made on a premium class basis. No change in premium will become effective until 40 days after a notification is sent to Your last known address, on Our Home Office Records.

THIS IS A SPECIFIED DISEASE POLICY, WHICH ONLY PROVIDES BENEFITS FOR THE DIAGNOSIS OF ILLNESSES SPECIFIED AND DEFINED IN THIS POLICY. IT DOES NOT PAY BENEFITS FOR LOSS FROM ANY OTHER CAUSE. THIS POLICY DOES NOT CONTAIN DEATH BENEFITS. IT CONTAINS WAITING PERIODS EXCLUSIONS AND LIMITATIONS.

THIS IS A LIMITED BENEFIT POLICY
READ IT CAREFULLY WITH THE OUTLINE OF COVERAGE

TABLE OF CONTENTS

POLICY SCHEDULE **[policy no]**

FORM NO.	DESCRIPTION	UNITS	PLAN	PREMIUM
[HH89]	[CRITICAL ILLNESS]	[XXX.XXX]	[HH89]	[$XXX.XX]

TOTAL ANNUAL PREMIUM **[$XXX.XX]**

RENEWAL PREMIUMS

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY
[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]

***THE FOLLOWING BENEFITS ARE PAID FOR COVERAGE PROVIDED BY*:**

1. **[CRITICAL ILLNESS BENEFITS** **BENEFIT AMOUNT (Based On XXX.XXX Units)**

	Primary Insured	Spouse	Per Child
Heart Attack	$ XXX	$ XXX	$ XXX
Coronary Artery Bypass Grafting	$ XXX	$ XXX	$ XXX
Coronary Artery Angioplasty	$ XXX	$ XXX	$ XXX
Stroke	$ XXX	$ XXX	$ XXX
Kidney Failure	$ XXX	$ XXX	$ XXX
Major Organ Transplant	$ XXX	$ XXX	$ XXX
CRITICAL ILLNESS BENEFIT MAXIMUM	$ XXX	$ XXX	$ XXX]

On a Covered Person's attained age 70, all Critical Illness Benefits and the Critical Illness Benefit Maximum, less any benefits previously paid, will be reduced by one-half (50%), for that Covered Person.

2. **[Optional Rider[(s)]]**

POLICY NUMBER:
[xxxxxxxxxx]

INSURED:
[John Doe]
[123 WALKING WAY]
[ANYTOWN, AL, 12345]

EFFECTIVE DATE:
[MM/DD/YYYY]

ISSUE AGE: [XX] SEX:[MALE]
SMOKING STATUS: [NON-SMOKER]
POLICY WAITING PERIOD: [30 days for all Benefits]

PREMIUM: [$XXX.XX]
PAYABLE EVERY: [MONTH]
COVERAGE TYPE: [INDIVIDUAL]

DEFINITIONS

As used in, and for the purposes of this Policy, the terms listed below will have the meanings as defined. The plural use of a term will share the same meaning as the singular.

AGE means the attained age as of the Covered Person's last birthday.

CLINICAL DIAGNOSIS means a Diagnosis and identification of a Covered Event or Covered Condition based on observation and history, diagnostic and laboratory studies, and symptoms.

COVERED EVENT or COVERED CONDITION means Heart Attack, Kidney Failure, Stroke, Major Organ Transplant, Coronary Artery Angioplasty, and Coronary Artery Bypass Grafting as each is defined in this Policy, including any applicable limitations and exclusions.

COVERED PERSONS are indicated by the Coverage Type as shown on the Policy Schedule Page as follows:

1) Individual: Only the Primary Insured listed on the Policy Schedule Page is covered.
2) Individual and Spouse: The Primary Insured and the Primary Insured's Legal Spouse as listed on the application or added/changed by endorsement are covered.
3) One Parent Family: The Primary Insured and all of the Primary Insured's legal Dependent Child(ren) as listed on the application or added/changed by endorsement are covered.
4) Two Parent Family: The Primary Insured, the Primary Insured's Legal Spouse as listed on the application or added/changed by endorsement and all of the Primary Insured's legal Dependent Child(ren) as listed on the application or added/changed by endorsement are covered.

Any person specifically excluded by name from coverage is NOT included as a Covered Person.

CRITICAL ILLNESS means only the illnesses or procedures listed in the Policy Schedule under "Critical Illness Benefits"

CRITICAL ILLNESS BENEFIT MAXIMUM means the maximum total dollar amount payable under this Policy stated in the Policy Schedule. The Critical Illness Benefit Maximum is reduced, for all Covered Persons, by fifty percent (50%) on the Covered Person's attained age of 70 years.

DATE OF DIAGNOSIS means the date the Covered Event or Covered Condition of a Critical Illness is first Diagnosed. It is NOT the date the Diagnosis is communicated to a Covered Person.

DEPENDENT CHILD OR DEPENDENT CHILDREN means any unmarried child (natural, step or adopted) of Yours who:

1) is less than nineteen (19) years old and living with You; or
2) is less than twenty-four (24) years old and attending an accredited school as a full time student. Such child must be legally dependent upon You for principal support and maintenance; or
3) is or becomes incapable of self-support because of mental or physical handicap while covered under this Policy and prior to attaining limiting age for Dependent Child(ren) under (1) or (2) above. The child must be legally dependent upon You for support and maintenance. We must receive proof of incapacity within thirty-one (31) days after coverage would otherwise terminate. Coverage will then continue as long as Your insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age twenty-four (24) at the Company's expense; or
4) is not living with You, but You are legally required to support such child, and the child would otherwise qualify under (1), (2) or (3) above.

The term Dependent Child(ren) does NOT include grandchild(ren) unless required by law.
Proof of legal status may be required from time to time on covered Dependent Child(ren).

DEFINITIONS (Continued)

DIAGNOSED or **DIAGNOSIS** means a definitive identification of the Critical Illness made by a Physician (where applicable, specializing in a particular area of medicine) and supported by documentation of all appropriate and defined studies:

1. based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
2. meets any diagnostic requirements stated in this Policy for the particular Critical Illness being diagnosed; and
3. performed during the lifetime of the Covered Person and includes a diagnosis after death.

EFFECTIVE DATE means the date that this Policy becomes effective. The Effective Date is stated on the Policy schedule page.

FRAUDULENT MISREPRESENTATIONS means information on the application that is stated incorrectly for the purposes of obtaining this Policy.

IMMEDIATE FAMILY OR **IMMEDIATE FAMILY MEMBER** includes anyone related to You or Your Legal Spouse in the following manner: spouse; brothers or sisters (including stepbrothers, stepsisters, half-brothers and half-sisters);children (including stepchildren); parents (including stepparents); grandparents (including step grandparents);grandchildren (including step-grandchildren); aunts and uncles; nieces and nephews; and spouses, as applicable, of any of the above.

INCUR or INCURRED means an event, incident, or condition that:
1. occurs on or after the Effective Date of this Policy, and
2. occurs while this Policy is in force, and
3. is Diagnosed during the life of the Covered Person and after death, and
4. is not specifically excluded by any definitions or exclusions in this Policy.

LEGAL SPOUSE means Your spouse as recognized by federal law. Once this Policy has been issued, any consideration of an addition of a spouse, whether by first marriage or remarriage, requires the submission of a completed application and is subject to Our approval. Spouse coverage terminates upon divorce of marriage. Proof of legal status may be required upon Our request from time to time on a covered spouse.

MANIFESTS or MANIFESTED means a condition or symptom that would cause an ordinary prudent person to seek medical advice, care, or treatment.

MONTH means a calendar month.

PHYSICIAN means a person who:
1. is a legally qualified medical practitioner in good standing and a Doctorate of the healing arts licensed in the United States or its territories; and
2. practices within the scope of his or her license and specialty in the United States or its territories; and
3. is not the Covered Person; or
4. is not the Covered Person’s Immediate Family Member or business associate; or
5. does not customarily reside in the same household as the Covered Person.

A Physician does NOT mean an emergency medical technician, nurse, nurse practitioner, physician’s assistant, coroner or other medical personnel that does not meet the above qualifications.

PRIMARY INSURED means the person named in the Policy Schedule Page.

DEFINITIONS (Continued)

REINSTATEMENT DATE means the date coverage under this Policy and any attached Riders becomes effective following Reinstatement. This date will be the date of Our approval in writing of the reinstatement of any coverage.

WE, OUR, COMPANY or US means Life Insurance Company of Alabama

YOU or YOUR refers to the Primary Insured named in the Policy Schedule.

CRITICAL ILLNESS BENEFITS

We will pay the Critical Illness Benefit amount stated in the Policy Schedule (subject to all applicable Policy provisions), if a Critical Illness is both Incurred (or Manifests, as stated in the Policy), and is Diagnosed more than 30 days after the Effective Date. Payment of the Primary Insured's Critical Illness Benefit Maximum terminates this Policy. Payment of the Critical Illness Benefit Maximum for a Covered Person terminates coverage for that Covered Person. The Critical Illness Benefit Maximum for a Covered Person is reduced by the amount of all Critical Illness Benefit amounts paid for that Covered Person. The total of all Critical Illness Benefit payments for a Covered Person cannot exceed the Critical Illness Benefit Maximum for that Covered Person as stated in the Policy Schedule. No Critical Illness Benefit for a Covered Person is payable more than once.

On a Covered Person's attained age 70, all Critical Illness Benefits and the Critical Illness Benefit Maximum, less any benefits previously paid, will be reduced by one-half (50%), for that Covered Person.

BENEFIT PAYMENT CONDITIONS

The payment of benefits for a Critical Illness stated in the Policy Schedule is subject to the following conditions:

(a) the Critical Illness Incurs and/or Manifests as stated in the Policy; and

(b) the Critical Illness is Diagnosed, Incurred and Manifested after the Policy Waiting Period following the Effective date of this Policy; and

(c) the benefit payment is not excluded by any general or specific exclusion or limitation; and

(d) the Critical Illness Diagnosis is made by a legally licensed Physician during the lifetime of the Insured and includes after death.

(e) All required Proofs of Loss must be received by the Company.

CRITICAL ILLNESS BENEFITS (Continued)

HEART ATTACK

For the purposes of this Policy, Heart Attack means an Acute Myocardial Infarction resulting in death of heart muscle due to inadequate blood supply. .

All of the following criteria for acute myocardial infarction must be satisfied:

1. Medical documentation of typical clinical symptoms, for example, central chest pain; and
2. diagnostic increase of specific cardiac markers or elevated cardiac enzymes; and
3. new electrocardiographic changes consistent with an Acute Myocardial Infarction; and
4. the Critical Illness Diagnosis of an Acute Myocardial Infarction must be made by a legally licensed Physician during the Covered Person's lifetime and includes after death.

Heart Attack does **not** mean a cardiac arrest, congestive heart failure, cardiopulmonary arrest or any condition other than an Acute Myocardial Infarction.

If a Heart Attack is Incurred, Manifested and Diagnosed more than 30 days after the Effective Date, We will pay the Heart Attack Benefit stated in the Policy schedule.

Heart Attack that is Incurred during or within 24 hours of any heart, cardiac or coronary artery medical procedure is excluded.

KIDNEY FAILURE

For the purposes of this Policy, Kidney Failure means chronic irreversible failure of **both** kidneys to function, as a result of which either regular renal or peritoneal dialysis, or renal transplant is initiated. The Critical Illness Diagnosis must be made by a legally licensed Physician during the Covered Person's lifetime and includes after death.

KIDNEY FAILURE BENEFIT

If Kidney Failure both Manifests and is Diagnosed more than 30 days after the Effective Date, We will pay the Kidney Failure Benefit stated in the Policy Schedule.

STROKE

For the purposes of this Policy, Stroke means death of brain tissue due to an acute cerebrovascular event. All of the following criteria for stroke must be satisfied:

1. clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage; and
2. clear evidence on a CT, MRI or similar imaging technique that a stroke has occurred; and
3. permanent neurologic deficit measured 30 days or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome; and
4. the Critical Illness Diagnosis must be made by a legally licensed Physician during the Covered Person's lifetime and includes after death.

Symptoms due to and conditions of transient ischemic attack, migraine, hypoxia, traumatic injury to brain tissue or blood vessels, and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

STROKE BENEFIT

If a Stroke is Incurred, Manifested and Diagnosed more than 30 days after the Effective Date, We will pay the Stroke Benefit stated in the Policy Schedule.

MAJOR ORGAN TRANSPLANT

For the purposes of this Policy, Major Organ Transplant means human to human organ transplant from a donor to the Covered Person of: bone marrow (solely for treatment of cancer or bone marrow failure), or transplant of an entire kidney, liver, heart, lung, or pancreas. Transplant of any other organs, parts of organs, tissues or cells are excluded.

MAJOR ORGAN TRANSPLANT BENEFIT

We will pay the Major Organ Transplant Benefit stated in the Policy schedule, if more than 30 days after the Effective Date both:

(a) the need for a Major Organ Transplant is first Diagnosed; and
(b) the Covered Person undergoes a Major Organ Transplant.

CORONARY ARTERY ANGIOPLASTY

For the purposes of this Policy, Coronary Artery Angioplasty means balloon angioplasty; laser angioplasty; angioplasty and stent placement; or atherectomy; to correct narrowing or blockage of one or more coronary arteries.

CORONARY ARTERY ANGIOPLASTY BENEFIT

We will pay the Coronary Artery Angioplasty Benefit stated in the Policy schedule if, more than 30 days after the Effective Date both:

(a) the need for a Coronary Artery Angioplasty is first Diagnosed; and
(b) the Covered Person undergoes a Coronary Artery Angioplasty.

All diagnostic procedures including, but not limited to, arteriograms, angiograms and cardiac catheterization are excluded.

This benefit is payable only once in the Covered Person's lifetime.

CORONARY ARTERY BYPASS GRAFTING

For the purposes of this Policy, Coronary Artery Bypass Grafting means major open heart surgery requiring median sternotomy (division of the breast bone) to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Procedures that do not require median sternotomy are excluded, including but not limited to, minimally invasive, endoscopic, and "keyhole" heart surgery; balloon and laser angioplasty; stent procedures; and atherectomy.

CORONARY ARTERY BYPASS GRAFTING BENEFIT

We will pay the Coronary Artery Bypass Grafting Benefit stated in the Policy schedule if, more than 30 days after the Effective Date both:

(a) the need for Coronary Artery Bypass Grafting is first Diagnosed; and
(b) the Covered Person undergoes Coronary Artery Bypass Grafting.

This benefit is payable only once in the Covered Person's lifetime**.**

RIGHT TO EXAMINE FOR ALL CRITICAL ILLNESSES

We reserve the right to conduct a physical examination of the Covered Person and/or review any Critical Illness Diagnosed by a Physician of Our choosing. Any expenses incurred for this examination will be paid by the Company. This Physician must:

(a) have specialty training and board certification in the field of Medicine specific to the Critical Illness being Diagnosed; and

(b) must follow all routinely accepted procedures and protocols in the Diagnosis of the Critical Illness.

EXCLUSIONS

We will NOT pay benefits for a loss while being, caused by, contributed to, or resulting from:

- Any act of war, declared or undeclared; or
- Active duty in the armed forces, National Guard, or any reserve unit; or
- Engaging in a felony, or participating in any riot or civil insurrection; or
- Engaging in an illegal activity; or participating in any riot or civil insurrection; or
- Any intentionally self-inflicted injury; suicide, or suicide attempt; or
- Under the influence of alcohol (including the operation of or passenger of a motor vehicle with a blood alcohol concentration in excess of the legal limit of the state in which the accident occurs) or a controlled substance unless legally prescribed and used in the manner consistent with that prescription; or
- Any benefits for conditions diagnosed outside of the United States unless the Diagnosis and Date of Diagnosis can be confirmed in the United States by a Physician; or
- Any illness, loss, or condition specifically excluded from the definition of any Critical Illness; or
- Any illness, loss, or condition not stated as a covered Critical Illness in this Policy; or
- Any Critical Illness in which ALL of the criteria and Proof of Loss has not been received by the Company.

TERMINATION OF INSURANCE

Insurance coverage for You and Your Legal Spouse, if covered, will continue until the earliest of:

1) the Primary Insured's 90th birthday; or
2) the date any premium for this Policy is in default beyond the end of its Grace Period; or
3) the premium due date following Your written request for its termination.

In the event of Your death, coverage on any remaining Covered Persons will not terminate provided We receive a copy of Your death certificate and Written Notice to continue coverage within thirty (30) days of the date of Your death. If Your covered Legal Spouse or Dependent Child dies, You may request in writing to remove them from Your coverage.

If Your Legal Spouse is a Covered Person under this Policy and You and Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage, insurance coverage provided by this Policy on Your former Legal Spouse will automatically terminate on the 61st day following the date of the decree of the dissolution of marriage subject to the Right of Conversion provision.

Insurance coverage on a Dependent Child will terminate automatically on the earliest of the following:

1) the date of the Dependent Child's marriage; or
2) the Dependent Child's nineteenth (19th) birthday, if not a full-time student at an accredited school; or
3) the Dependent Child's twenty-fourth (24th) birthday, if a full-time student at an accredited school and legally dependent on You for principal support and maintenance.

Insurance coverage will not terminate due to the Dependent Child's age if the child is both:

1) incapable of self-sustaining employment because of mental or physical handicap; and
2) currently dependent upon You for support and maintenance.

You ***must*** provide proof of the Dependent Child's mental or physical handicap and dependence upon You within thirty-one (31) days after coverage would otherwise terminate in order for coverage to continue under this Policy. Proof of continued incapacity and dependency ***must be*** furnished at Our request.

Termination of Dependents is subject to the Right of Conversion provision.

RIGHT OF CONVERSION

If You and Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage and Your Legal Spouse was a Covered Person under this Policy, then Your former Legal Spouse may apply and receive, without evidence of insurability, a Policy providing coverage NOT greater than the terminated coverage. To obtain the Policy, Your former Legal Spouse must make application to Us within sixty (60) days following the date of the decree of dissolution of marriage. The Primary Insured under this Policy at the time of the dissolution of marriage shall remain the Primary Insured under this Policy. Coverage terminates automatically for the former Legal Spouse on the 61st day following the date of the decree of the dissolution of marriage. Any covered Dependent Children may be covered under either Policy, but NOT both.

A Covered Person whose dependency terminates and who desires to continue coverage as a Primary Insured under a separate Policy may do so by notifying Us of the request in writing. The Dependent Child will have the right to continue coverage as the Primary Insured under a separate Policy providing coverage NOT greater than the previous coverage without a requirement for evidence of insurability and without interruption in coverage. To obtain the Policy, the Dependent Child must make application to Us within thirty-one (31) days after the termination of insurance under this Policy.

In order to be considered for coverage, any Legal Spouse or Dependent Child not listed on the initial application must make written application.

GENERAL PROVISIONS

ENTIRE CONTRACT

This Policy, with the attached application, any other pages, amendments, or endorsements attached, and any application for reinstatement, are the entire contract between You and Us. This contract is made in consideration of Your application and payment of premiums as required. We rely on all statements in the application and any application for reinstatement as being true to the best of Your knowledge. No change to this Policy will be valid unless it is in writing and signed by an authorized Officer of Life Insurance Company of Alabama. No agent or other representative has authority to change or waive any Policy provisions or extend the time for paying a premium.

PAYMENT OF PREMIUMS

The due date of the initial premium is the Policy Effective Date. The initial premium may be paid to Our Home Office or to one of the Company's authorized agents. Premiums after the initial premium must be paid to Our Home Office at P.O. Box 349, Gadsden, AL 35902. Upon receipt of Your death certificate, We will refund any premium paid for any monthly period following the date of death. The refund may be paid to Your estate or designated Beneficiary. Upon receipt of Your written notice to discontinue coverage, We will refund any premium paid for any monthly period following the date We received the written notice from You. The refund may be paid to You.

This Policy is not effective until the Effective Date regardless of the date of the first premium payment if any premium is paid prior to the Effective Date. Any premium received prior to issue of the Policy will be held pending issue of the Policy. If the Policy is not issued by Us, We will refund any premium being held. If We or any third party on Our behalf receive premiums by any method (including payroll deduction and bank draft) prior to the issue of this Policy, We assume NO liability for coverage until this Policy is issued by Us. Premiums must be paid in United States currency.

GRACE PERIOD

This Policy has a thirty (30) day Grace Period for paying premium. This means if a renewal premium is not paid by the date due, it may be paid during the following thirty (30) days. Any otherwise payable claim incurred during the Grace Period will NOT be paid until the past due premiums are paid provided the Policy has not lapsed or terminated.

LAPSE

Your Policy will lapse if any premium is not paid before the end of the Grace Period. The date of lapse will be the date that the unpaid premium was due. Your Policy will terminate upon lapse as of the last date to which premiums have been paid and provide NO further benefits.

GENERAL PROVISIONS (Continued)

REINSTATEMENT

If Your Policy lapses, You may request to reinstate it by:

1. submitting a written application for reinstatement within 60 days after the end of the Grace Period; and
2. providing any additional evidence of insurability as We may require; and
3. paying all required premium.

If We approve Your request for reinstatement, coverage will become effective as of the Reinstatement Date. Unless we have previously sent you a written notice of disapproval, the Policy will be reinstated on the 45th day after Our receipt of the required evidence of insurability or such earlier date that We approve such evidence.

We will not pay benefits for any Critical Illness that Incurs or Manifests, whichever is applicable as stated in this Policy, and/or is Diagnosed: before the end of 30 days after the Reinstatement Date.

Your rights and Our obligations under this Policy will be the same as before the Policy lapsed subject to the Reinstatement and Incontestable provisions.

If You do not request a reinstatement within 90 days from the date any unpaid premium was due, this Policy will remain terminated and no further benefits will be provided.

UNEARNED PREMIUM REFUND

If You die before the end of a Premium Period for which premium has been paid, We will refund the portion of premium, prorated monthly, that was applied to coverage for the time period beyond the end of the month in which death occurred.

NOTICE OF CLAIM

You must provide Us with written notice of claim within 60 days from the Date of Diagnosis, or as soon as reasonably possible. You must provide notice of claim at Our Home Office. Your notice of claim must include the Covered Person, Your name, address, the Policy Number, and the Covered Condition or Covered Event for which the Covered Personis claiming

CLAIM FORMS

When We receive Your notice of claim, we will provide You with the forms required to file a claim. If you do not receive the forms within 15 days, You will have met the time frame required for filing Your claim. if You have provided Us with a written statement of the nature and extent of Your loss and sufficient Proof of Loss within the time allowed for filing a Proof of Loss.

PROOF OF LOSS

You must provide Us with written Proof of Loss determined to be satisfactory to Us within 90 days from the Date of Diagnosis. If it is not reasonably possible for You to provide written Proof of Loss within the stated time, Your claim will not be affected if You provide the written Proof of Loss as soon as reasonably possible but in no event later than 12 months from the Date of Diagnosis.

Proof of Loss includes the claim form (or written statement as noted in Claim Forms section above), plus appropriate evidence needed to establish benefit eligibility, which may include, but not limited to, physician or hospital records, histo-pathological reports, operative reports and test reports.

You must provide to Us any authorizations to obtain medical records or other information needed to evaluate your claim.

TIME OF PAYMENT OF CLAIMS

We will pay benefits within thirty (30) working days once We receive sufficient written Proof of Loss. If We do not pay benefits upon receipt of your claim, We shall have thirty (30) working days thereafter within which to mail to You a letter or notice which states the reasons We have for not paying the claim, either in whole or in part, and which also gives You a notice of any documents or other information needed to process the claim. When We have received sufficient written Proof of Loss from You, We shall then have thirty (30) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

PAYMENT OF CLAIMS

We will pay all benefits to You; benefits under this Policy are not subject to assignment. Upon receipt of Your death certificate, any benefits that have not been paid at the time of Your death may be paid to Your estate or Your designated Beneficiary. We have the right to pay up to $1,000 of those benefits to any Immediate Family Member who We believe is justly entitled to such payment. If We make a payment under this provision in good faith, We will be released from liability to the extent of the payment.

LEGAL ACTIONS

No legal action may be brought to recover benefits on this Policy before 60 days after We have received sufficient written Proof of Loss. No legal action may be brought against us more than two (2) years from the date written Proof of Loss was required to be provided.

AGE AND GENDER

If a Covered Person's Age or Gender is not correct as shown in this Policy, all benefits payable under this Policy will be such as the premium paid would have purchased at the correct Age or Gender. If the correct age is such that we would have obtained additional underwriting requirements or would not have issued this Policy, We will only be liable for a refund of any premiums paid for the period for which there was no coverage.

CONTESTABLE PERIOD

After two (2) years from the Effective Date (or the Reinstatement Date, if the Policy has been reinstated), no misstatements, except Fraudulent Misstatements, made by You in the application (or reinstatement application) shall be used to void this Policy or to deny a claim with a Date of Diagnosis after the expiration of such two (2) year contestable period. The Date of Diagnosis determines whether or not a claim is within the Contestable Period, NOT when the claim is received by Us. Misstatements, including Fraudulent Misstatements, made by You on the Application (or reinstatement application) may be used by Us to void this Policy or to deny a claim with a Date of Diagnosis within two (2) years after the Effective Date or within two (2) years after the Reinstatement of this Policy.

EFFECTIVE DATE

This Policy's Effective Date is the date shown on the Policy Schedule. This Policy will take effect at 12:01 AM in the time zone of Your last known address, on our Home Office records on the Effective Date. This Policy will terminate at 11:59 PM in the time zone of Your last known address, on our Home Office records on the date of termination. If this Policy lapses and is reinstated, the Effective Date is as described in the Reinstatement Provision.

GENERAL PROVISIONS (Continued)

TERMINATION

This Policy will terminate on the earliest of:

(a) the date on which this Policy lapses or terminates; or
(b) the date that the Primary Insured's Critical Illness Benefit Maximum is paid; or
(c) any premium due date requested by You in writing to terminate this Policy; or
(d) the end of the Grace Period following the due date for which a premium was not paid; or
(e) the death of the Primary Insured; or
(f) The Primary Insured's age 90.

OWNER

The Insured is the Owner of this Policy unless later changed.

As Owner, You may exercise all rights in this Policy while the Insured Person is living. If You are without legal capacity, We will allow Your rights to be exercised by:

(a) a legally appointed Guardian responsible for Your property; or
(b) a person who We determine is responsible for Your welfare and support.

To exercise Your rights, You must follow the procedures stated in this Policy. All elections, designations, changes and requests must be made in writing and in a form acceptable to Us.

If You change Your beneficiary, address, or request any other action by Us, You should do so on the form prepared for each purpose. You may obtain such forms from Our Home Office at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, AL 35902.

BENEFICIARY

The beneficiary designated by You in the application or later changed on Our records will receive any benefits unpaid at Your death. Each beneficiary is classified as a Primary or Contingent Beneficiary. All surviving beneficiaries of the same class will share equally in any payments to that class, unless otherwise designated by You.

If no stated beneficiary is living at the time of Your Death, We will pay:

(a) the executor or administrator of Your estate; or
(b) Your spouse, child, or parent who We determine is entitled to payment

CHANGE OF OWNER OR BENEFICIARY

While the Insured Person is living, You may change:

(a) the Owner; or
(b) a Beneficiary designation, if it is not restricted by a previous designation.

We require that any change be endorsed by an authorized Officer of Our Company. Any change will be effective the date of Our endorsement. No agent or other representative has authority to endorse this Policy.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy that, on the coverage effective date, conflicts with any laws of the state where You lived when this Policy was issued, is amended to conform with the law.

Life Insurance Company of Alabama

302 Broad Street
Gadsden, Alabama 35901
800-226-2371

CRITICAL ILLNESS BENEFIT POLICY

Form Number HH892012

OUTLINE OF COVERAGE

THE POLICY PROVIDES LIMITED BENEFITS

THE POLICY IS A SPECIFIED DISEASE INDEMNITY POLICY WHICH ONLY PROVIDES BENEFITS FOR CERTAIN CRITICAL ILLNESS. IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS, CONDITION OR INCAPACITY.

THIS IS A LIMITED BENEFIT POLICY – PLEASE READ YOUR POLICY CAREFULLY - This outline of coverage provides a very brief description of some of the important features of the policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and the Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

CRITICAL ILLNESS INSURANCE COVERAGE – Policies of this category are designed to provide persons insured, restricted coverage paying ONLY when certain losses occur as a certain critical illness. Coverage is not provided for basic hospital, basic medical-surgical, or major medical or comprehensive expenses.

BENEFITS

Qualifying For Benefits
We will pay the Critical Illness Benefit selected, if a Critical Illness is Incurred (or Manifests) and is Diagnosed more than 30 days after the Effective Date.

Critical Illness Benefit

1. The Critical Illness Benefit Maximum is reduced by the amount of all Critical Illness Benefit amounts paid.
2. The total of all Critical Illness Benefit payments cannot exceed the Critical Illness Benefit Maximum.
3. No Critical Illness Benefit is payable more than once.
4. Payment of the Critical Illness Benefit Maximum terminates the policy.
5. On Your attained age 70, all Critical Illness Benefits and the Critical Illness Benefit Maximum, less any benefits previously paid, will be reduced by one-half (50%).

Benefit Payment Conditions
The payment of benefits for a Critical Illness is subject to the following conditions:

1. The benefit payment is not excluded by any general or specific exclusion or limitation.
2. The Critical Illness Diagnosis is made by a legally licensed Physician during the lifetime of a Covered Person and not post mortem. No benefits are payable for Critical Illness Diagnosis made after the death of a Covered Person.

Critical Illness
In the policy, the term Critical Illness means a Heart Attack, Kidney Failure, Stroke, Major Organ Transplant, Coronary Artery Angioplasty and Coronary Artery Bypass Grafting. Benefits are not provided for any other Critical Illness.

Heart Attack Benefit
We will pay the Heart Attack Benefit if a Heart Attack is Incurred, Manifested and Diagnosed more than 30 days after the Effective Date of the policy. A Heart Attack that is Incurred during or within 24 hours of any heart, cardiac or coronary artery medical procedure is excluded.

A Heart Attack means an Acute Myocardial Infarction resulting in death of heart muscle due to inadequate blood supply. .
All of the following criteria for acute myocardial infarction must be satisfied:

1. Medical documentation of typical clinical symptoms, for example, central chest pain; and
2. diagnostic increase of specific cardiac markers or elevated cardiac enzymes; and
3. new electrocardiographic changes consistent with an Acute Myocardial Infarction.
4. The Critical Illness Diagnosis of an Acute Myocardial Infarction must be made by a legally licensed Physician during Your lifetime and not post mortem..

Heart Attack does not mean a cardiac arrest, congestive heart failure, cardiopulmonary arrest or any condition other than an Acute Myocardial Infarction.

Kidney Failure Benefit

We will pay the Kidney Failure Benefit if Kidney Failure both Manifests and is Diagnosed more than 30 days after the Effective Date of the policy.

Kidney Failure means chronic irreversible failure of both kidneys to function, as a result of which either regular renal or peritoneal dialysis, or renal transplant is initiated. The Critical Illness Diagnosis must be made by a legally licensed Physician during Your lifetime and not post mortem.

Stroke Benefit
We will pay the Stroke Benefit if a Stroke is Incurred, Manifested and Diagnosed more than 30 days after the Effective Date of the policy.

A Stroke means death of brain tissue due to an acute cerebrovascular event. All of the following criteria for stroke must be satisfied:

1. clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage;
2. clear evidence on a CT, MRI or similar imaging technique that a stroke has occurred; and
3. permanent neurologic deficit measured 30 days or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome.
4. The Critical Illness Diagnosis must be made by a legally licensed Physician during Your lifetime and not post mortem.

Symptoms due to and conditions of transient ischemic attack, migraine, hypoxia, traumatic injury to brain tissue or blood vessels, and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

Major Organ Transplant Benefit
We will pay the Major Organ Transplant Benefit if more than 30 days after the Effective Date of the policy both.

1. the need for a Major Organ Transplant is first Diagnosed; and
2. the insured undergoes a Major Organ Transplant.

A Major Organ Transplant means human to human organ transplant from a donor to the Insured of: bone marrow (solely for treatment of cancer or bone marrow failure), or transplant of an entire kidney, liver, heart, lung, or pancreas. Transplant of any other organs, parts of organs, tissues or cells are excluded.

Coronary Artery Angioplasty Benefit
We will pay the Coronary Artery Angioplasty Benefit if more than 30 days after the Effective Date of the policy both.

1. the need for a Coronary Artery Angioplasty is first Diagnosed; and
2. the insured undergoes a Coronary Artery Angioplasty.

A Coronary Artery Angioplasty means balloon angioplasty; laser angioplasty; angioplasty and stent placement; or atherectomy; to correct narrowing or blockage of one or more coronary arteries.

Coronary Artery Bypass Grafting Benefit
We will pay the Coronary Artery Bypass Grafting Benefit if more than 30 days after the Effective Date of the policy both.

1. the need for a Coronary Artery Bypass Grafting is first Diagnosed; and
2. the insured undergoes a Coronary Artery Bypass Grafting.

Coronary Artery Bypass Grafting means major open heart surgery requiring median sternotomy (division of the breast bone) to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Procedures that do not require median sternotomy are excluded, including but not limited to, minimally invasive, endoscopic, and "keyhole" heart surgery; balloon and laser angioplasty; stent procedures; and atherectomy.

Important Definitions

Critical Illness Benefit Maximum means the maximum total dollar amount payable under the policy. The Critical Illness Benefit Maximum is reduced by fifty percent (50%) on Your attained age of 70 years.

Diagnosed or Diagnosis means a definitive identification of the Critical Illness made by a Physician (where applicable, specializing in a particular area of medicine) and supported by documentation of all appropriate and defined studies:

1. based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
2. meets any diagnostic requirements stated in the policy for the particular Critical Illness being diagnosed; and
3. performed during the lifetime of the Insured and not post-mortem.

Effective Date means the date that the policy becomes effective.

Important Definitions (Continued)

Incur or Incurred means an event, incident, or condition that:

1. occurs on or after the Effective Date of the policy, and
2. occurs while the policy is in force, and
3. is Diagnosed during the life of the insured and not post mortem, and
4. is not specifically excluded by any definitions or exclusions in the policy.

Manifests or Manifested means a condition or symptom that would cause an ordinary prudent person to seek medical advice, care, or treatment.

Physician means a person who:

1. is a legally qualified medical practitioner in good standing and a Doctorate of the healing arts licensed in the United States or its territories; and
2. practices within the scope of his or her license and specialty in the United States or its territories; and
3. is not the insured person; or
4. is not the insured person's immediate family member or business associate; or
5. does not customarily reside in the same household as the insured person.

A Physician does NOT mean an emergency medical technician, nurse, nurse practitioner, physician's assistant, coroner or other medical personnel that does not meet the above qualifications.

Exclusions and Limitations

We will not pay benefits for a loss while being, caused by, contributed to, or resulting from:

- ❑ Any act of war, declared or undeclared, or
- ❑ Active duty in the armed forces, National Guard, or any reserve unit, or
- ❑ Engaging in a felony, or participating in any riot or civil insurrection; or
- ❑ Engaging in an illegal activity; or participating in any riot or civil insurrection; or
- ❑ Any intentionally self-inflicted injury; suicide, or suicide attempt, or
- ❑ Under the influence of alcohol (including the operation of or passenger of a motor vehicle with a blood alcohol concentration in excess of the legal limit of the state in which the accident occurs) or a controlled substance unless legally prescribed and used in the manner consistent with that prescription; or
- ❑ Any benefits for conditions diagnosed outside of the United States unless the Diagnosis and Date of Diagnosis can be confirmed in the United States by a Physician; or
- ❑ Any illness, loss, or condition specifically excluded from the definition of any Critical Illness
- ❑ Any illness, loss, or condition not stated as a covered Critical Illness in the policy.
- ❑ Any Diagnosis made after the death of the insured.
- ❑ Any Critical Illness in which ALL of the criteria and Proof of Loss has not been received by the Company.

Renewability

You may continue the coverage provided by the policy by paying all premiums when due, until the policy anniversary on or following the expiry date, subject to the policy's termination provision.

Premium.

We reserve the right to change the premium rates for the policy. Any change in premium will be made on a premium class basis. No change in premium will become effective until 40 days after a notification is sent to your last known address, on Our Home Office Records.

Benefit Amount Selections		**Premium**
Critical Illness Base Plan		**$** _____
Critical Illness Maximum Benefit Amount		
Heart Attack Benefit	_____	
Kidney Failure Benefit	_____	
Stroke Benefit	_____	
Major Organ Transplant Benefit	_____	
Coronary Artery Angioplasty Benefit	_____	
Coronary Artery Bypass Grafting	_____	
Optional Riders		
☐ **Wellness Rider**		**$** _____
	Total Premium	**$** _____

LICOA
Life Insurance Company of Alabama
HOME OFFICE • GADSDEN, ALABAMA 35902

Protecting your financial security

CRITICAL ILLNESS BENEFIT POLICY

This is a Limited Benefit Policy

LIFE INSURANCE COMPANY OF ALABAMA agrees to pay the benefits according to the provisions of this Policy. All benefits are subject to its provisions, exclusions and limitations. This Policy is a legal contract between You and Us.

Signed for the Company at Gadsden, Alabama.

Secretary President

CONSIDERATION

This Policy is issued to You in consideration of Your application and the receipt of the first premium. This Policy is a legal contract between You and Us. Your Policy is effective at 12:01 a.m. on the Effective Date in the time zone of Your home address as indicated on the Policy Schedule page.

NOTICE OF RIGHT TO EXAMINE POLICY

You should read this entire contract carefully and refer to the DEFINITIONS section to understand the meaning of defined words. The application and any amendments or riders are a part of this contract. You must review and give special attention to make sure all of the information in the application and amendments are accurate and complete. You must notify Us of any information that is inaccurate, incomplete or omitted within thirty (30) days after delivery of this Policy. You may return this Policy within thirty (30) days after the delivery if You are not satisfied with it for any reason to: Life Insurance Company of Alabama, PO Box 349, Gadsden, AL 35902. The return of this Policy will void it from the Effective Date and any premium We receive will be refunded. If premium is not returned within thirty (30) days of Our receipt of cancellation, We will pay interest on the premium at the rate then in effect as determined by Oklahoma law.

GUARANTEED RENEWABLE TO AGE 90
SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS BY CLASS

You may continue the coverage provided by this Policy by paying all premiums when due, until the Policy anniversary on or following the Expiry Date, subject to the Policy's Termination provision. We reserve the right to change the premium rates for this Policy. Any change in premium will be made on a premium class basis. No change in premium will become effective until sixty (60) days after a notification is sent to Your last known address, on Our Home Office Records.

THIS IS A SPECIFIED DISEASE POLICY, WHICH ONLY PROVIDES BENEFITS FOR THE DIAGNOSIS OF ILLNESSES SPECIFIED AND DEFINED IN THIS POLICY. IT DOES NOT PAY BENEFITS FOR LOSS FROM ANY OTHER CAUSE. THIS POLICY DOES NOT CONTAIN DEATH BENEFITS. PLEASE READ THE CONTRACT CAREFULLY – IT CONTAINS WAITING PERIODS EXCLUSIONS AND LIMITATIONS.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive us, makes any claim proceeds of this Policy containing false, incomplete, or misleading information is guilty of a felony.

TABLE OF CONTENTS

POLICY SCHEDULE PAGE **[policy no]**

FORM NO.	DESCRIPTION	UNITS	PLAN	PREMIUM
[HH89]	[CRITICAL ILLNESS]	[XXX.XXX]	[HH89]	[$XXX.XX]

TOTAL ANNUAL PREMIUM **[$XXX.XX]**

RENEWAL PREMIUMS

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY
[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]

***THE FOLLOWING BENEFITS ARE PAID FOR COVERAGE PROVIDED BY*:**

1. **[CRITICAL ILLNESS BENEFITS** **BENEFIT MAXIMUM (Amounts Based On XXX.XXX Units)**

Heart Attack	**$ XXX**
Coronary Artery Bypass Grafting	**$ XXX**
Coronary Artery Angioplasty	**$ XXX**
Stroke	**$ XXX**
Kidney Failure	**$ XXX**
Major Organ Transplant	**$ XXX]**
[Legal Spouse	**50% of the primary insured amount]**
[Dependent Children	**25%, per dependent child, of the primary insured amount]**

The Benefit Maximum is Subject to a reduction of fifty percent (50%) on the Covered Person's attained age 70.

2. **[Optional Rider[(s)]]**

POLICY NUMBER:
[xxxxxxxxxx]

INSURED:
[John Doe]
[123 WALKING WAY]
[ANYTOWN, AL, 12345]

EFFECTIVE DATE:
[MM/DD/YYYY]

ISSUE AGE: [XX] SEX:[MALE]
SMOKING STATUS: [NON-SMOKER]
POLICY WAITING PERIOD: [30 days for all Benefits]

PREMIUM: [$XXX.XX]
PAYABLE EVERY: [MONTH]

DEFINITIONS

As used in, and for the purposes of this Policy, the terms listed below will have the meanings as defined. The plural use of a term will share the same meaning as the singular.

AGE means the attained age as of Your last birthday.

CLINICAL DIAGNOSIS means a Diagnosis and identification of a Covered Event or Covered Condition based on observation and history, diagnostic and laboratory studies, and symptoms.

COVERED EVENT or COVERED CONDITION means Heart Attack, Kidney Failure, Stroke, Major Organ Transplant, Coronary Artery Angioplasty, and Coronary Artery Bypass Grafting as each is defined in this Policy, including any applicable limitations and exclusions.

CRITICAL ILLNESS means only the illnesses or procedures listed in the Policy Schedule under "Critical Illness Benefits"

CRITICAL ILLNESS BENEFIT MAXIMUM means the maximum total dollar amount payable under this Policy stated in the Policy Schedule. The Critical Illness Benefit Maximum is reduced by fifty percent (50%) on Your attained age of 70 years.

DATE OF DIAGNOSIS means the date the Covered Event or Covered Condition of a Critical Illness is first Diagnosed. It is NOT the date the Diagnosis is communicated to You.

DEPENDENT CHILD OR DEPENDENT CHILDREN means any unmarried child (natural, step or adopted) of Yours who:

1) is less than nineteen (19) years old and living with You; or
2) is less than twenty-four (24) years old and attending an accredited school as a full time student. Such child must be legally dependent upon You for principal support and maintenance; or
3) is or becomes incapable of self-support because of mental or physical handicap while covered under this Policy and prior to attaining limiting age for Dependent Child(ren) under (1) or (2) above. The child must be legally dependent upon You for support and maintenance. We must receive proof of incapacity within thirty-one (31) days after coverage would otherwise terminate. Coverage will then continue as long as Your insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age twenty-four (24); or
4) is not living with You, but You are legally required to support such child, and the child would otherwise qualify under (1), (2) or (3) above.

The term Dependent Child(ren) does NOT include grandchild(ren) unless required by law.

Proof of legal status may be required from time to time on covered Dependent Child(ren).

DEFINITIONS (Continued)

DIAGNOSED or **DIAGNOSIS** means a definitive identification of the Critical Illness made by a Physician (where applicable, specializing in a particular area of medicine) and supported by documentation of all appropriate and defined studies:

1. based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
2. meets any diagnostic requirements stated in this Policy for the particular Critical Illness being diagnosed; and
3. performed during the lifetime of the Insured and not post-mortem.

EFFECTIVE DATE means the date that this Policy becomes effective. The Effective Date is stated on the Policy schedule page.

FRAUDULENT MISREPRESENTATIONS means information on the application that is stated incorrectly for the purposes of obtaining this Policy.

IMMEDIATE FAMILY OR **IMMEDIATE FAMILY MEMBER** includes anyone related to You or Your Legal Spouse in the following manner: spouse; brothers or sisters (including stepbrothers, stepsisters, half-brothers and half-sisters);children (including stepchildren); parents (including stepparents); grandparents (including step grandparents);grandchildren (including step-grandchildren); aunts and uncles; nieces and nephews; and spouses, as applicable, of any of the above.

INCUR or INCURRED means an event, incident, or condition that:
1. occurs on or after the Effective Date of this Policy, and
2. occurs while this Policy is in force, and
3. is Diagnosed during the life of the insured and not post mortem, and
4. is not specifically excluded by any definitions or exclusions in this Policy.

INSURED means the person named in the Policy Schedule Page.

LEGAL SPOUSE means Your spouse as recognized by federal law. Once this Policy has been issued, any consideration of an addition of a spouse, whether by first marriage or remarriage, requires the submission of a completed application and is subject to Our approval. Spouse coverage terminates upon divorce of marriage. Proof of legal status may be required upon Our request from time to time on a covered spouse.

MANIFESTS or MANIFESTED means a condition or symptom that would cause an ordinary prudent person to seek medical advice, care, or treatment.

MONTH means a calendar month.

PHYSICIAN means a person who:
1. is a legally qualified medical practitioner in good standing and a Doctorate of the healing arts licensed in the United States or its territories; and
2. practices within the scope of his or her license and specialty in the United States or its territories; and
3. is not the Insured Person; or
4. is not the Insured Person's Immediate Family Member or business associate; or
5. does not customarily reside in the same household as the Insured Person.

A Physician does NOT mean an emergency medical technician, nurse, nurse practitioner, physician's assistant, coroner or other medical personnel that does not meet the above qualifications.

DEFINITIONS (Continued)

REINSTATEMENT DATE means the date coverage under this Policy and any attached Riders becomes effective following Reinstatement. This date will be the date of Our approval in writing of the reinstatement of any coverage.

WE, OUR, COMPANY or US means Life Insurance Company of Alabama

YOU or YOUR refers to the Insured named in the Policy Schedule.

CRITICAL ILLNESS BENEFITS

We will pay the Critical Illness Benefit amount stated in the Policy Schedule (subject to all applicable Policy provisions), if a Critical Illness is both Incurred (or Manifests, as stated in the Policy), and is Diagnosed more than 30 days after the Effective Date. Payment of the Critical Illness Benefit Maximum terminates this Policy. The Critical Illness Benefit Maximum is reduced by the amount of all Critical Illness Benefit amounts paid. The total of all Critical Illness Benefit payments cannot exceed the Critical Illness Benefit Maximum as stated in the Policy Schedule. No Critical Illness Benefit is payable more than once.

On Your attained age 70, all Critical Illness Benefits and the Critical Illness Benefit Maximum, less any benefits previously paid, will be reduced by one-half (50%).

BENEFIT PAYMENT CONDITIONS

The payment of benefits for a Critical Illness stated in the Policy Schedule is subject to the following conditions:

(a) the Critical Illness Incurs and/or Manifests as stated in the Policy; and

(b) the Critical Illness is Diagnosed, Incurred and Manifested after the Policy Waiting Period following the Effective date of this Policy; and

(c) the benefit payment is not excluded by any general or specific exclusion or limitation; and

(d) the Critical Illness Diagnosis is made by a legally licensed Physician during the lifetime of the Insured and not post mortem. No benefits are payable for Critical Illness Diagnosis made after the death of the Insured.

(e) All required Proofs of Loss must be received by the Company.

HEART ATTACK

For the purposes of this Policy, Heart Attack means an Acute Myocardial Infarction resulting in death of heart muscle due to inadequate blood supply. .

All of the following criteria for acute myocardial infarction must be satisfied:

1. Medical documentation of typical clinical symptoms, for example, central chest pain; and
2. diagnostic increase of specific cardiac markers or elevated cardiac enzymes; and
3. new electrocardiographic changes consistent with an Acute Myocardial Infarction; and
4. the Critical Illness Diagnosis of an Acute Myocardial Infarction must be made by a legally licensed Physician during Your lifetime and not post mortem.

Heart Attack does **not** mean a cardiac arrest, congestive heart failure, cardiopulmonary arrest or any condition other than an Acute Myocardial Infarction.

CRITICAL ILLNESS BENEFITS (Continued)

HEART ATTACK BENEFIT

If a Heart Attack is Incurred, Manifested and Diagnosed more than 30 days after the Effective Date, We will pay the Heart Attack Benefit stated in the Policy schedule.

Heart Attack that is Incurred during or within 24 hours of any heart, cardiac or coronary artery medical procedure is excluded.

KIDNEY FAILURE

For the purposes of this Policy, Kidney Failure means chronic irreversible failure of **both** kidneys to function, as a result of which either regular renal or peritoneal dialysis, or renal transplant is initiated. The Critical Illness Diagnosis must be made by a legally licensed Physician during Your lifetime and not post mortem.

KIDNEY FAILURE BENEFIT

If Kidney Failure both Manifests and is Diagnosed more than 30 days after the Effective Date, We will pay the Kidney Failure Benefit stated in the Policy Schedule.

STROKE

For the purposes of this Policy, Stroke means death of brain tissue due to an acute cerebrovascular event. All of the following criteria for stroke must be satisfied:

1. clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage; and
2. clear evidence on a CT, MRI or similar imaging technique that a stroke has occurred; and
3. permanent neurologic deficit measured 30 days or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome; and
4. the Critical Illness Diagnosis must be made by a legally licensed Physician during Your lifetime and not post mortem.

Symptoms due to and conditions of transient ischemic attack, migraine, hypoxia, traumatic injury to brain tissue or blood vessels, and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

STROKE BENEFIT

If a Stroke is Incurred, Manifested and Diagnosed more than 30 days after the Effective Date, We will pay the Stroke Benefit stated in the Policy Schedule.

MAJOR ORGAN TRANSPLANT

For the purposes of this Policy, Major Organ Transplant means human to human organ transplant from a donor to the Insured of: bone marrow (solely for treatment of cancer or bone marrow failure), or transplant of an entire kidney, liver, heart, lung, or pancreas. Transplant of any other organs, parts of organs, tissues or cells are excluded.

MAJOR ORGAN TRANSPLANT BENEFIT

We will pay the Major Organ Transplant Benefit stated in the Policy schedule, if more than 30 days after the Effective Date both:

(a) the need for a Major Organ Transplant is first Diagnosed; and

(b) the Insured undergoes a Major Organ Transplant.

CORONARY ARTERY ANGIOPLASTY

For the purposes of this Policy, Coronary Artery Angioplasty means balloon angioplasty; laser angioplasty; angioplasty and stent placement; or atherectomy; to correct narrowing or blockage of one or more coronary arteries.

CORONARY ARTERY ANGIOPLASTY BENEFIT

We will pay the Coronary Artery Angioplasty Benefit stated in the Policy schedule if, more than 30 days after the Effective Date both:

(a) the need for a Coronary Artery Angioplasty is first Diagnosed; and

(b) the Insured undergoes a Coronary Artery Angioplasty.

All diagnostic procedures including, but not limited to, arteriograms, angiograms and cardiac catheterization are excluded.

This benefit is payable only once in the Insured's lifetime.

CORONARY ARTERY BYPASS GRAFTING

For the purposes of this Policy, Coronary Artery Bypass Grafting means major open heart surgery requiring median sternotomy (division of the breast bone) to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Procedures that do not require median sternotomy are excluded, including but not limited to, minimally invasive, endoscopic, and "keyhole" heart surgery; balloon and laser angioplasty; stent procedures; and atherectomy.

CORONARY ARTERY BYPASS GRAFTING BENEFIT

We will pay the Coronary Artery Bypass Grafting Benefit stated in the Policy schedule if, more than 30 days after the Effective Date both:

(a) the need for Coronary Artery Bypass Grafting is first Diagnosed; and

(b) the Insured undergoes Coronary Artery Bypass Grafting.

This benefit is payable only once in the Insured's lifetime**.**

RIGHT TO EXAMINE FOR ALL CRITICAL ILLNESSES

We reserve the right to conduct a physical examination of the Insured and/or review any Critical Illness Diagnosed by a Physician of Our choosing. This Physician must:

(a) have specialty training and board certification in the field of Medicine specific to the Critical Illness being Diagnosed; and

(b) must follow all routinely accepted procedures and protocols in the Diagnosis of the Critical Illness.

EXCLUSIONS

We will NOT pay benefits for a loss while being, caused by, contributed to, or resulting from:

- Any act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntary or as required by an employer; or
- Active duty in the armed forces, National Guard, or any reserve unit; or
- Engaging in a felony, or participating in any riot or civil insurrection; or
- Engaging in an illegal activity; or participating in any riot or civil insurrection; or
- Any intentionally self-inflicted injury; suicide, or suicide attempt; or
- Any loss resulting from being under the influence of any drugs or narcotic unless administered on the advice of a Doctor; or
- Any benefits for conditions diagnosed outside of the United States unless the Diagnosis and Date of Diagnosis can be confirmed in the United States by a Physician; or
- Any illness, loss, or condition specifically excluded from the definition of any Critical Illness; or
- Any illness, loss, or condition not stated as a covered Critical Illness in this Policy; or
- Any Diagnosis made after the death of the Insured; or
- Any Critical Illness in which ALL of the criteria and Proof of Loss has not been received by the Company.

TERMINATION OF INSURANCE

Insurance coverage for You and Your Legal Spouse, if covered, will continue until the earliest of:

1) the Primary Insured's 90th birthday; or
2) the date any premium for this Policy is in default beyond the end of its Grace Period; or
3) the premium due date following Your written request for its termination.

In the event of Your death, coverage on any remaining Covered Persons will not terminate provided We receive a copy of Your death certificate and Written Notice to continue coverage within thirty (30) days of the date of Your death. If Your covered Legal Spouse or Dependent Child dies, You may request in writing to remove them from Your coverage.

If Your Legal Spouse is a Covered Person under this Policy and You and Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage, insurance coverage provided by this Policy on Your former Legal Spouse will automatically terminate on the 61st day following the date of the decree of the dissolution of marriage.

Insurance coverage on a Dependent Child will terminate automatically on the earliest of the following:

1) the date of the Dependent Child's marriage; or
2) the Dependent Child's nineteenth (19th) birthday, if not a full-time student at an accredited school; or
3) the Dependent Child's twenty-fourth (24th) birthday, if a full-time student at an accredited school and legally dependent on You for principal support and maintenance.

TERMINATION OF INSURANCE (Continued)

Insurance coverage will not terminate due to the Dependent Child's age if the child is both:

1) incapable of self-sustaining employment because of mental or physical handicap; and
2) currently dependent upon You for support and maintenance.

You ***must*** provide proof of the Dependent Child's mental or physical handicap and dependence upon You within thirty-one (31) days after coverage would otherwise terminate in order for coverage to continue under this Policy. Proof of continued incapacity and dependency ***must be*** furnished at Our request.

RIGHT OF CONVERSION

If You and Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage and Your Legal Spouse was a Covered Person under this Policy, then Your former Legal Spouse may apply and receive, without evidence of insurability, a Policy providing coverage NOT greater than the terminated coverage. To obtain the Policy, Your former Legal Spouse must make application to Us within sixty (60) days following the date of the decree of dissolution of marriage. The Primary Insured under this Policy at the time of the dissolution of marriage shall remain the Primary Insured under this Policy. Coverage terminates automatically for the former Legal Spouse on the 61st day following the date of the decree of the dissolution of marriage. Any covered Dependent Children may be covered under either Policy, but NOT both.

A Covered Person whose dependency terminates and who desires to continue coverage as a Primary Insured under a separate Policy may do so by notifying Us of the request in writing. The Dependent Child will have the right to continue coverage as the Primary Insured under a separate Policy providing coverage NOT greater than the previous coverage without a requirement for evidence of insurability and without interruption in coverage. To obtain the Policy, the Dependent Child must make application to Us within thirty-one (31) days after the termination of insurance under this Policy.

In order to be considered for coverage, any Legal Spouse or Dependent Child not listed on the initial application must make written application.

GENERAL PROVISIONS

ENTIRE CONTRACT

This Policy, with the attached application, any other pages, amendments, or endorsements attached, and any application for reinstatement, are the entire contract between You and Us. This contract is made in consideration of Your application and payment of premiums as required. We rely on all statements in the application and any application for reinstatement as being true to the best of Your knowledge. No change to this Policy will be valid unless it is in writing and signed by an authorized Officer of Life Insurance Company of Alabama. No agent or other representative has authority to change or waive any Policy provisions or extend the time for paying a premium.

GENERAL PROVISIONS (Continued)

PAYMENT OF PREMIUMS

The due date of the initial premium is the Policy Effective Date. The initial premium may be paid to Our Home Office or to one of the Company's authorized agents. Premiums after the initial premium must be paid to Our Home Office at P.O. Box 349, Gadsden, AL 35902. Upon receipt of Your death certificate, We will refund any premium paid for any monthly period following the date of death. The refund may be paid to Your estate or designated Beneficiary. Upon receipt of Your written notice to discontinue coverage, We will refund any premium paid for any monthly period following the date We received the written notice from You. The refund may be paid to You.

This Policy is not effective until the Effective Date regardless of the date of the first premium payment if any premium is paid prior to the Effective Date. Any premium received prior to issue of the Policy will be held pending issue of the Policy. If the Policy is not issued by Us, We will refund any premium being held. If We or any third party on Our behalf receive premiums by any method (including payroll deduction and bank draft) prior to the issue of this Policy, We assume NO liability for coverage until this Policy is issued by Us. Premiums must be paid in United States currency.

GRACE PERIOD

This Policy has a thirty (30) day Grace Period for paying premium. This means if a renewal premium is not paid by the date due, it may be paid during the following thirty (30) days. Any otherwise payable claim incurred during the Grace Period will NOT be paid until the past due premiums are paid provided the Policy has not lapsed or terminated.

LAPSE

Your Policy will lapse if any premium is not paid before the end of the Grace Period. The date of lapse will be the date that the unpaid premium was due. Your Policy will terminate upon lapse as of the last date to which premiums have been paid and provide NO further benefits.

REINSTATEMENT

If Your Policy lapses, You may request to reinstate it by:

1. submitting a written application for reinstatement within 60 days after the end of the Grace Period; and
2. providing any additional evidence of insurability as We may require; and
3. paying all required premium.

If We approve Your request for reinstatement, coverage will become effective as of the Reinstatement Date. Unless we have previously sent you a written notice of disapproval, the Policy will be reinstated on the 45th day after Our receipt of the required evidence of insurability or such earlier date that We approve such evidence.

We will not pay benefits for any Critical Illness that Incurs or Manifests, whichever is applicable as stated in this Policy, and/or is Diagnosed: before the end of 30 days after the Reinstatement Date.

Your rights and Our obligations under this Policy will be the same as before the Policy lapsed subject to the Reinstatement and Incontestable provisions.

If You do not request a reinstatement within 90 days from the date any unpaid premium was due, this Policy will remain terminated and no further benefits will be provided.

GENERAL PROVISIONS (Continued)

UNEARNED PREMIUM REFUND

If You die before the end of a Premium Period for which premium has been paid, We will refund the portion of premium, prorated monthly, that was applied to coverage for the time period beyond the end of the month in which death occurred.

NOTICE OF CLAIM

You must provide Us with written notice of claim within 60 days from the Date of Diagnosis, or as soon as reasonably possible, but in no event later than 180 days from the Date of Diagnosis. You must provide notice of claim at Our Home Office. Your notice of claim must include Your name, address, the Policy Number, and the Covered Condition or Covered Event for which you are claiming

CLAIM FORMS

When We receive Your notice of claim, we will provide You with the forms required to file a claim. If you do not receive the forms within 15 days, You will have met the time frame required for filing Your claim. if You have provided Us with a written statement of the nature and extent of Your loss and sufficient Proof of Loss within the time allowed for filing a Proof of Loss.

PROOF OF LOSS

You must provide Us with written Proof of Loss determined to be satisfactory to Us within 90 days from the Date of Diagnosis. If it is not reasonably possible for You to provide written Proof of Loss within the stated time, Your claim will not be affected if You provide the written Proof of Loss as soon as reasonably possible but in no event later than 12 months from the Date of Diagnosis.

Proof of Loss includes the claim form (or written statement as noted in Claim Forms section above), plus appropriate evidence needed to establish benefit eligibility, which may include, but not limited to, physician or hospital records, histo-pathological reports, operative reports and test reports.

You must provide to Us any authorizations to obtain medical records or other information needed to evaluate your claim.

TIME OF PAYMENT OF CLAIMS

We will pay benefits within thirty (30) working days once We receive sufficient written Proof of Loss. If We do not pay benefits upon receipt of your claim, We shall have thirty (30) working days thereafter within which to mail to You a letter or notice which states the reasons We have for not paying the claim, either in whole or in part, and which also gives You a notice of any documents or other information needed to process the claim. When We have received sufficient written Proof of Loss from You, We shall then have thirty (30) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

PAYMENT OF CLAIMS

We will pay all benefits to You; benefits under this Policy are not subject to assignment. Upon receipt of Your death certificate, any benefits that have not been paid at the time of Your death may be paid to Your estate or Your designated Beneficiary. We have the right to pay up to $1,000 of those benefits to any Immediate Family Member who We believe is justly entitled to such payment. If We make a payment under this provision in good faith, We will be released from liability to the extent of the payment.

GENERAL PROVISIONS (Continued)

LEGAL ACTIONS

No legal action may be brought to recover benefits on this Policy before 60 days after We have received sufficient written Proof of Loss. No legal action may be brought against us more than three (3) years from the date written Proof of Loss was required to be provided.

AGE AND GENDER

If an Insured Person's Age or Gender is not correct as shown in this Policy, all benefits payable under this Policy will be such as the premium paid would have purchased at the correct Age or Gender. If the correct age is such that we would have obtained additional underwriting requirements or would not have issued this Policy, We will only be liable for a refund of any premiums paid for the period for which there was no coverage.

CONTESTABLE PERIOD

After two (2) years from the Effective Date (or the Reinstatement Date, if the Policy has been reinstated), no misstatements, except Fraudulent Misstatements, made by You in the application (or reinstatement application) shall be used to void this Policy or to deny a claim with a Date of Diagnosis after the expiration of such two (2) year contestable period. If We do not receive sufficient documentation from You to properly investigate Your claim that is within this 2 year contestable period, We retain the right to void the Policy and refund all premiums We have received. We will provide You with written notice fifteen (15) days before the Policy is voided. The Date of Diagnosis determines whether or not a claim is within the Contestable Period, NOT when the claim is received by Us. Misstatements, including Fraudulent Misstatements, made by You on the Application (or reinstatement application) may be used by Us to void this Policy or to deny a claim with a Date of Diagnosis within two (2) years after the Effective Date or within two (2) years after the Reinstatement of this Policy.

EFFECTIVE DATE

This Policy's Effective Date is the date shown on the Policy Schedule. This Policy will take effect at 12:01 AM in the time zone of Your last known address, on our Home Office records on the Effective Date. This Policy will terminate at 11:59 PM in the time zone of Your last known address, on our Home Office records on the date of termination. If this Policy lapses and is reinstated, the Effective Date is as described in the Reinstatement Provision.

TERMINATION

This Policy will terminate on the earliest of:

(a) the date on which this Policy lapses or terminates; or

(b) the date that the Critical Illness Benefit Maximum is paid; or

(c) any premium due date requested by You in writing to terminate this Policy; or

(d) the end of the Grace Period following the due date for which a premium was not paid; or

(e) the death of the Primary Insured; or

(f) The Primary Insured's age 90.

GENERAL PROVISIONS (Continued)

OWNER

The Insured is the Owner of this Policy unless later changed.

As Owner, You may exercise all rights in this Policy while the Insured Person is living. If You are without legal capacity, We will allow Your rights to be exercised by:

(a) a legally appointed Guardian responsible for Your property; or

(b) a person who We determine is responsible for Your welfare and support.

To exercise Your rights, You must follow the procedures stated in this Policy. All elections, designations, changes and requests must be made in writing and in a form acceptable to Us.

If You change Your beneficiary, address, or request any other action by Us, You should do so on the form prepared for each purpose. You may obtain such forms from Our Home Office at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, AL 35902.

BENEFICIARY

The beneficiary designated by You in the application or later changed on Our records will receive any benefits unpaid at Your death. Each beneficiary is classified as a Primary or Contingent Beneficiary. All surviving beneficiaries of the same class will share equally in any payments to that class, unless otherwise designated by You.

If no stated beneficiary is living at the time of Your Death, We will pay:

(a) the executor or administrator of Your estate; or

(b) Your spouse, child, or parent who We determine is entitled to payment

CHANGE OF OWNER OR BENEFICIARY

While the Insured Person is living, You may change:

(a) the Owner; or

(b) a Beneficiary designation, if it is not restricted by a previous designation.

We require that any change be endorsed by an authorized Officer of Our Company. Any change will be effective the date of Our endorsement. No agent or other representative has authority to endorse this Policy.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy that, on the coverage effective date, conflicts with any laws of the state where You lived when this Policy was issued, is amended to conform with the law.

LICOA
Life Insurance Company of Alabama
HOME OFFICE • GADSDEN, ALABAMA 35902

Protecting your financial security

CRITICAL ILLNESS BENEFIT POLICY

This is a Limited Benefit Policy

LIFE INSURANCE COMPANY OF ALABAMA agrees to pay the benefits according to the provisions of this Policy. All benefits are subject to its provisions, exclusions and limitations. This Policy is a legal contract between You and Us.

Signed for the Company at Gadsden, Alabama.

Secretary

President

CONSIDERATION

This Policy is issued to You in consideration of Your application and the receipt of the first premium. This Policy is a legal contract between You and Us. Your Policy is effective at 12:01 a.m. on the Effective Date in the time zone of Your home address as indicated on the Policy Schedule page.

NOTICE OF RIGHT TO EXAMINE POLICY

You should read this entire contract carefully and refer to the DEFINITIONS section to understand the meaning of defined words. The application and any amendments or riders are a part of this contract. You must review and give special attention to make sure all of the information in the application and amendments are accurate and complete. You must notify Us of any information that is inaccurate, incomplete or omitted within thirty (30) days after delivery of this Policy. You may return this Policy within thirty (30) days after the delivery if You are not satisfied with it for any reason to: Life Insurance Company of Alabama, PO Box 349, Gadsden, AL 35902. The return of this Policy will void it from the Effective Date and any premium We receive will be refunded.

GUARANTEED RENEWABLE TO AGE 90
SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS BY CLASS

You may continue the coverage provided by this Policy by paying all premiums when due, until the Policy anniversary on or following the Expiry Date, subject to the Policy's Termination provision. We reserve the right to change the premium rates for this Policy. Any change in premium will be made on a premium class basis. No change in premium will become effective until 40 days after a notification is sent to Your last known address, on Our Home Office Records.

THIS IS A SPECIFIED DISEASE POLICY, WHICH ONLY PROVIDES BENEFITS FOR THE DIAGNOSIS OF ILLNESSES SPECIFIED AND DEFINED IN THIS POLICY. IT DOES NOT PAY BENEFITS FOR LOSS FROM ANY OTHER CAUSE. THIS POLICY DOES NOT CONTAIN DEATH BENEFITS. PLEASE READ THE CONTRACT CAREFULLY – IT CONTAINS WAITING PERIODS EXCLUSIONS AND LIMITATIONS.

TABLE OF CONTENTS

POLICY SCHEDULE PAGE **[policy no]**

FORM NO.	DESCRIPTION	UNITS	PLAN	PREMIUM
[HH89]	[CRITICAL ILLNESS]	[XXX.XXX]	[HH89]	[$XXX.XX]

TOTAL ANNUAL PREMIUM **[$XXX.XX]**

RENEWAL PREMIUMS

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY
[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]

***THE FOLLOWING BENEFITS ARE PAID FOR COVERAGE PROVIDED BY*:**

1. **[CRITICAL ILLNESS BENEFITS** **BENEFIT MAXIMUM (Amounts Based On XXX.XXX Units)**

Heart Attack	**$ XXX**
Coronary Artery Bypass Grafting	**$ XXX**
Coronary Artery Angioplasty	**$ XXX**
Stroke	**$ XXX**
Kidney Failure	**$ XXX**
Major Organ Transplant	**$ XXX]**
[Legal Spouse	**50% of the primary insured amount]**
[Dependent Children	**25%, per dependent child, of the primary insured amount]**

The Benefit Maximum is Subject to a reduction of fifty percent (50%) on the Covered Person's attained age 70.

2. **[Optional Rider[(s)]]**

POLICY NUMBER:
[xxxxxxxxxx]

INSURED:
[John Doe]
[123 WALKING WAY]
[ANYTOWN, AL, 12345]

EFFECTIVE DATE:
[MM/DD/YYYY]

ISSUE AGE: [XX] SEX:[MALE]
SMOKING STATUS: [NON-SMOKER]
POLICY WAITING PERIOD: [30 days for all Benefits]

PREMIUM: [$XXX.XX]
PAYABLE EVERY: [MONTH]

DEFINITIONS

As used in, and for the purposes of this Policy, the terms listed below will have the meanings as defined. The plural use of a term will share the same meaning as the singular.

AGE means the attained age as of Your last birthday.

CLINICAL DIAGNOSIS means a Diagnosis and identification of a Covered Event or Covered Condition based on observation and history, diagnostic and laboratory studies, and symptoms.

COVERED EVENT or COVERED CONDITION means Heart Attack, Kidney Failure, Stroke, Major Organ Transplant, Coronary Artery Angioplasty, and Coronary Artery Bypass Grafting as each is defined in this Policy, including any applicable limitations and exclusions.

CRITICAL ILLNESS means only the illnesses or procedures listed in the Policy Schedule under "Critical Illness Benefits"

CRITICAL ILLNESS BENEFIT MAXIMUM means the maximum total dollar amount payable under this Policy stated in the Policy Schedule. The Critical Illness Benefit Maximum is reduced by fifty percent (50%) on Your attained age of 70 years.

DATE OF DIAGNOSIS means the date the Covered Event or Covered Condition of a Critical Illness is first Diagnosed. It is NOT the date the Diagnosis is communicated to You.

DEPENDENT CHILD OR DEPENDENT CHILDREN means any unmarried child (natural, step or adopted) of Yours who:

1) is less than nineteen (19) years old and living with You; or
2) is less than twenty-four (24) years old and attending an accredited school as a full time student. Such child must be legally dependent upon You for principal support and maintenance; or
3) is or becomes incapable of self-support because of mental or physical handicap while covered under this Policy and prior to attaining limiting age for Dependent Child(ren) under (1) or (2) above. The child must be legally dependent upon You for support and maintenance. We must receive proof of incapacity within thirty-one (31) days after coverage would otherwise terminate. Coverage will then continue as long as Your insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age twenty-four (24); or
4) is not living with You, but You are legally required to support such child, and the child would otherwise qualify under (1), (2) or (3) above.

The term Dependent Child(ren) does NOT include grandchild(ren) unless required by law.

Proof of legal status may be required from time to time on covered Dependent Child(ren).

DEFINITIONS (Continued)

DIAGNOSED or **DIAGNOSIS** means a definitive identification of the Critical Illness made by a Physician (where applicable, specializing in a particular area of medicine) and supported by documentation of all appropriate and defined studies:

1. based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
2. meets any diagnostic requirements stated in this Policy for the particular Critical Illness being diagnosed; and
3. performed during the lifetime of the Insured and not post-mortem.

EFFECTIVE DATE means the date that this Policy becomes effective. The Effective Date is stated on the Policy schedule page.

FRAUDULENT MISREPRESENTATIONS means information on the application that is stated incorrectly for the purposes of obtaining this Policy.

IMMEDIATE FAMILY OR **IMMEDIATE FAMILY MEMBER** includes anyone related to You or Your Legal Spouse in the following manner: spouse; brothers or sisters (including stepbrothers, stepsisters, half-brothers and half-sisters);children (including stepchildren); parents (including stepparents); grandparents (including step grandparents);grandchildren (including step-grandchildren); aunts and uncles; nieces and nephews; and spouses, as applicable, of any of the above.

INCUR or INCURRED means an event, incident, or condition that:
1. occurs on or after the Effective Date of this Policy, and
2. occurs while this Policy is in force, and
3. is Diagnosed during the life of the insured and not post mortem, and
4. is not specifically excluded by any definitions or exclusions in this Policy.

INSURED means the person named in the Policy Schedule Page.

LEGAL SPOUSE means Your spouse as recognized by federal law. Once this Policy has been issued, any consideration of an addition of a spouse, whether by first marriage or remarriage, requires the submission of a completed application and is subject to Our approval. Spouse coverage terminates upon divorce of marriage. Proof of legal status may be required upon Our request from time to time on a covered spouse.

MANIFESTS or MANIFESTED means a condition or symptom that would cause an ordinary prudent person to seek medical advice, care, or treatment.

MONTH means a calendar month.

PHYSICIAN means a person who:
1. is a legally qualified medical practitioner in good standing and a Doctorate of the healing arts licensed in the United States or its territories; and
2. practices within the scope of his or her license and specialty in the United States or its territories; and
3. is not the Insured Person; or
4. is not the Insured Person's Immediate Family Member or business associate; or
5. does not customarily reside in the same household as the Insured Person.

A Physician does NOT mean an emergency medical technician, nurse, nurse practitioner, physician's assistant, coroner or other medical personnel that does not meet the above qualifications.

DEFINITIONS (Continued)

REINSTATEMENT DATE means the date coverage under this Policy and any attached Riders becomes effective following Reinstatement. This date will be the date of Our approval in writing of the reinstatement of any coverage.

WE, OUR, COMPANY or US means Life Insurance Company of Alabama

YOU or YOUR refers to the Insured named in the Policy Schedule.

CRITICAL ILLNESS BENEFITS

We will pay the Critical Illness Benefit amount stated in the Policy Schedule (subject to all applicable Policy provisions), if a Critical Illness is both Incurred (or Manifests, as stated in the Policy), and is Diagnosed more than 30 days after the Effective Date. Payment of the Critical Illness Benefit Maximum terminates this Policy. The Critical Illness Benefit Maximum is reduced by the amount of all Critical Illness Benefit amounts paid. The total of all Critical Illness Benefit payments cannot exceed the Critical Illness Benefit Maximum as stated in the Policy Schedule. No Critical Illness Benefit is payable more than once.

On Your attained age 70, all Critical Illness Benefits and the Critical Illness Benefit Maximum, less any benefits previously paid, will be reduced by one-half (50%).

BENEFIT PAYMENT CONDITIONS

The payment of benefits for a Critical Illness stated in the Policy Schedule is subject to the following conditions:

(a) the Critical Illness Incurs and/or Manifests as stated in the Policy; and

(b) the Critical Illness is Diagnosed, Incurred and Manifested after the Policy Waiting Period following the Effective date of this Policy; and

(c) the benefit payment is not excluded by any general or specific exclusion or limitation; and

(d) the Critical Illness Diagnosis is made by a legally licensed Physician during the lifetime of the Insured and not post mortem. No benefits are payable for Critical Illness Diagnosis made after the death of the Insured.

(e) All required Proofs of Loss must be received by the Company.

HEART ATTACK

For the purposes of this Policy, Heart Attack means an Acute Myocardial Infarction resulting in death of heart muscle due to inadequate blood supply. .

All of the following criteria for acute myocardial infarction must be satisfied:

1. Medical documentation of typical clinical symptoms, for example, central chest pain; and
2. diagnostic increase of specific cardiac markers or elevated cardiac enzymes; and
3. new electrocardiographic changes consistent with an Acute Myocardial Infarction; and
4. the Critical Illness Diagnosis of an Acute Myocardial Infarction must be made by a legally licensed Physician during Your lifetime and not post mortem.

Heart Attack does **not** mean a cardiac arrest, congestive heart failure, cardiopulmonary arrest or any condition other than an Acute Myocardial Infarction.

CRITICAL ILLNESS BENEFITS (Continued)

HEART ATTACK BENEFIT

If a Heart Attack is Incurred, Manifested and Diagnosed more than 30 days after the Effective Date, We will pay the Heart Attack Benefit stated in the Policy schedule.

Heart Attack that is Incurred during or within 24 hours of any heart, cardiac or coronary artery medical procedure is excluded.

KIDNEY FAILURE

For the purposes of this Policy, Kidney Failure means chronic irreversible failure of **both** kidneys to function, as a result of which either regular renal or peritoneal dialysis, or renal transplant is initiated. The Critical Illness Diagnosis must be made by a legally licensed Physician during Your lifetime and not post mortem.

KIDNEY FAILURE BENEFIT

If Kidney Failure both Manifests and is Diagnosed more than 30 days after the Effective Date, We will pay the Kidney Failure Benefit stated in the Policy Schedule.

STROKE

For the purposes of this Policy, Stroke means death of brain tissue due to an acute cerebrovascular event. All of the following criteria for stroke must be satisfied:

1. clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage; and
2. clear evidence on a CT, MRI or similar imaging technique that a stroke has occurred; and
3. permanent neurologic deficit measured 30 days or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome; and
4. the Critical Illness Diagnosis must be made by a legally licensed Physician during Your lifetime and not post mortem.

Symptoms due to and conditions of transient ischemic attack, migraine, hypoxia, traumatic injury to brain tissue or blood vessels, and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

STROKE BENEFIT

If a Stroke is Incurred, Manifested and Diagnosed more than 30 days after the Effective Date, We will pay the Stroke Benefit stated in the Policy Schedule.

MAJOR ORGAN TRANSPLANT

For the purposes of this Policy, Major Organ Transplant means human to human organ transplant from a donor to the Insured of: bone marrow (solely for treatment of cancer or bone marrow failure), or transplant of an entire kidney, liver, heart, lung, or pancreas. Transplant of any other organs, parts of organs, tissues or cells are excluded.

MAJOR ORGAN TRANSPLANT BENEFIT

We will pay the Major Organ Transplant Benefit stated in the Policy schedule, if more than 30 days after the Effective Date both:

(a) the need for a Major Organ Transplant is first Diagnosed; and

(b) the Insured undergoes a Major Organ Transplant.

CORONARY ARTERY ANGIOPLASTY

For the purposes of this Policy, Coronary Artery Angioplasty means balloon angioplasty; laser angioplasty; angioplasty and stent placement; or atherectomy; to correct narrowing or blockage of one or more coronary arteries.

CORONARY ARTERY ANGIOPLASTY BENEFIT

We will pay the Coronary Artery Angioplasty Benefit stated in the Policy schedule if, more than 30 days after the Effective Date both:

(a) the need for a Coronary Artery Angioplasty is first Diagnosed; and

(b) the Insured undergoes a Coronary Artery Angioplasty.

All diagnostic procedures including, but not limited to, arteriograms, angiograms and cardiac catheterization are excluded.

This benefit is payable only once in the Insured's lifetime.

CORONARY ARTERY BYPASS GRAFTING

For the purposes of this Policy, Coronary Artery Bypass Grafting means major open heart surgery requiring median sternotomy (division of the breast bone) to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Procedures that do not require median sternotomy are excluded, including but not limited to, minimally invasive, endoscopic, and "keyhole" heart surgery; balloon and laser angioplasty; stent procedures; and atherectomy.

CORONARY ARTERY BYPASS GRAFTING BENEFIT

We will pay the Coronary Artery Bypass Grafting Benefit stated in the Policy schedule if, more than 30 days after the Effective Date both:

(a) the need for Coronary Artery Bypass Grafting is first Diagnosed; and

(b) the Insured undergoes Coronary Artery Bypass Grafting.

This benefit is payable only once in the Insured's lifetime**.**

RIGHT TO EXAMINE FOR ALL CRITICAL ILLNESSES

We reserve the right to conduct a physical examination of the Insured and/or review any Critical Illness Diagnosed by a Physician of Our choosing. This Physician must:

(a) have specialty training and board certification in the field of Medicine specific to the Critical Illness being Diagnosed; and

(b) must follow all routinely accepted procedures and protocols in the Diagnosis of the Critical Illness.

EXCLUSIONS

We will NOT pay benefits for a loss while being, caused by, contributed to, or resulting from:

- Any act of war, declared or undeclared; or
- Active duty in the armed forces, National Guard, or any reserve unit; or
- Engaging in a felony, or participating in any riot or civil insurrection; or
- Engaging in an illegal activity; or participating in any riot or civil insurrection; or
- Any intentionally self-inflicted injury; suicide, or suicide attempt; or
- Under the influence of alcohol (including the operation of or passenger of a motor vehicle with a blood alcohol concentration in excess of the legal limit of the state in which the accident occurs) or a controlled substance unless legally prescribed and used in the manner consistent with that prescription; or
- Any benefits for conditions diagnosed outside of the United States unless the Diagnosis and Date of Diagnosis can be confirmed in the United States by a Physician; or
- Any illness, loss, or condition specifically excluded from the definition of any Critical Illness; or
- Any illness, loss, or condition not stated as a covered Critical Illness in this Policy; or
- Any Diagnosis made after the death of the Insured; or
- Any Critical Illness in which ALL of the criteria and Proof of Loss has not been received by the Company.

TERMINATION OF INSURANCE

Insurance coverage for You and Your Legal Spouse, if covered, will continue until the earliest of:

1) the Primary Insured's 90th birthday; or
2) the date any premium for this Policy is in default beyond the end of its Grace Period; or
3) the premium due date following Your written request for its termination.

In the event of Your death, coverage on any remaining Covered Persons will not terminate provided We receive a copy of Your death certificate and Written Notice to continue coverage within thirty (30) days of the date of Your death. If Your covered Legal Spouse or Dependent Child dies, You may request in writing to remove them from Your coverage.

If Your Legal Spouse is a Covered Person under this Policy and You and Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage, insurance coverage provided by this Policy on Your former Legal Spouse will automatically terminate on the 61st day following the date of the decree of the dissolution of marriage.

Insurance coverage on a Dependent Child will terminate automatically on the earliest of the following:

1) the date of the Dependent Child's marriage; or
2) the Dependent Child's nineteenth (19th) birthday, if not a full-time student at an accredited school; or
3) the Dependent Child's twenty-fourth (24th) birthday, if a full-time student at an accredited school and legally dependent on You for principal support and maintenance.

TERMINATION OF INSURANCE (Continued)

Insurance coverage will not terminate due to the Dependent Child's age if the child is both:

1) incapable of self-sustaining employment because of mental or physical handicap; and
2) currently dependent upon You for support and maintenance.

You ***must*** provide proof of the Dependent Child's mental or physical handicap and dependence upon You within thirty-one (31) days after coverage would otherwise terminate in order for coverage to continue under this Policy. Proof of continued incapacity and dependency ***must be*** furnished at Our request.

RIGHT OF CONVERSION

If You and Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage and Your Legal Spouse was a Covered Person under this Policy, then Your former Legal Spouse may apply and receive, without evidence of insurability, a Policy providing coverage NOT greater than the terminated coverage. To obtain the Policy, Your former Legal Spouse must make application to Us within sixty (60) days following the date of the decree of dissolution of marriage. The Primary Insured under this Policy at the time of the dissolution of marriage shall remain the Primary Insured under this Policy. Coverage terminates automatically for the former Legal Spouse on the 61st day following the date of the decree of the dissolution of marriage. Any covered Dependent Children may be covered under either Policy, but NOT both.

A Covered Person whose dependency terminates and who desires to continue coverage as a Primary Insured under a separate Policy may do so by notifying Us of the request in writing. The Dependent Child will have the right to continue coverage as the Primary Insured under a separate Policy providing coverage NOT greater than the previous coverage without a requirement for evidence of insurability and without interruption in coverage. To obtain the Policy, the Dependent Child must make application to Us within thirty-one (31) days after the termination of insurance under this Policy.

In order to be considered for coverage, any Legal Spouse or Dependent Child not listed on the initial application must make written application.

GENERAL PROVISIONS

ENTIRE CONTRACT

This Policy, with the attached application, any other pages, amendments, or endorsements attached, and any application for reinstatement, are the entire contract between You and Us. This contract is made in consideration of Your application and payment of premiums as required. We rely on all statements in the application and any application for reinstatement as being true to the best of Your knowledge. No change to this Policy will be valid unless it is in writing and signed by an authorized Officer of Life Insurance Company of Alabama. No agent or other representative has authority to change or waive any Policy provisions or extend the time for paying a premium.

GENERAL PROVISIONS (Continued)

PAYMENT OF PREMIUMS

The due date of the initial premium is the Policy Effective Date. The initial premium may be paid to Our Home Office or to one of the Company's authorized agents. Premiums after the initial premium must be paid to Our Home Office at P.O. Box 349, Gadsden, AL 35902. Upon receipt of Your death certificate, We will refund any premium paid for any monthly period following the date of death. The refund may be paid to Your estate or designated Beneficiary. Upon receipt of Your written notice to discontinue coverage, We will refund any premium paid for any monthly period following the date We received the written notice from You. The refund may be paid to You.

This Policy is not effective until the Effective Date regardless of the date of the first premium payment if any premium is paid prior to the Effective Date. Any premium received prior to issue of the Policy will be held pending issue of the Policy. If the Policy is not issued by Us, We will refund any premium being held. If We or any third party on Our behalf receive premiums by any method (including payroll deduction and bank draft) prior to the issue of this Policy, We assume NO liability for coverage until this Policy is issued by Us. Premiums must be paid in United States currency.

GRACE PERIOD

This Policy has a thirty (30) day Grace Period for paying premium. This means if a renewal premium is not paid by the date due, it may be paid during the following thirty (30) days. Any otherwise payable claim incurred during the Grace Period will NOT be paid until the past due premiums are paid provided the Policy has not lapsed or terminated.

LAPSE

Your Policy will lapse if any premium is not paid before the end of the Grace Period. The date of lapse will be the date that the unpaid premium was due. Your Policy will terminate upon lapse as of the last date to which premiums have been paid and provide NO further benefits.

REINSTATEMENT

If Your Policy lapses, You may request to reinstate it by:

1. submitting a written application for reinstatement within 60 days after the end of the Grace Period; and
2. providing any additional evidence of insurability as We may require; and
3. paying all required premium.

If We approve Your request for reinstatement, coverage will become effective as of the Reinstatement Date. Unless we have previously sent you a written notice of disapproval, the Policy will be reinstated on the 45th day after Our receipt of the required evidence of insurability or such earlier date that We approve such evidence.

We will not pay benefits for any Critical Illness that Incurs or Manifests, whichever is applicable as stated in this Policy, and/or is Diagnosed: before the end of 30 days after the Reinstatement Date.

Your rights and Our obligations under this Policy will be the same as before the Policy lapsed subject to the Reinstatement and Incontestable provisions.

If You do not request a reinstatement within 90 days from the date any unpaid premium was due, this Policy will remain terminated and no further benefits will be provided.

GENERAL PROVISIONS (Continued)

UNEARNED PREMIUM REFUND

If You die before the end of a Premium Period for which premium has been paid, We will refund the portion of premium, prorated monthly, that was applied to coverage for the time period beyond the end of the month in which death occurred.

NOTICE OF CLAIM

You must provide Us with written notice of claim within 60 days from the Date of Diagnosis, or as soon as reasonably possible, but in no event later than 180 days from the Date of Diagnosis. You must provide notice of claim at Our Home Office. Your notice of claim must include Your name, address, the Policy Number, and the Covered Condition or Covered Event for which you are claiming

CLAIM FORMS

When We receive Your notice of claim, we will provide You with the forms required to file a claim. If you do not receive the forms within 15 days, You will have met the time frame required for filing Your claim. if You have provided Us with a written statement of the nature and extent of Your loss and sufficient Proof of Loss within the time allowed for filing a Proof of Loss.

PROOF OF LOSS

You must provide Us with written Proof of Loss determined to be satisfactory to Us within 90 days from the Date of Diagnosis. If it is not reasonably possible for You to provide written Proof of Loss within the stated time, Your claim will not be affected if You provide the written Proof of Loss as soon as reasonably possible but in no event later than 12 months from the Date of Diagnosis.

Proof of Loss includes the claim form (or written statement as noted in Claim Forms section above), plus appropriate evidence needed to establish benefit eligibility, which may include, but not limited to, physician or hospital records, histo-pathological reports, operative reports and test reports.

You must provide to Us any authorizations to obtain medical records or other information needed to evaluate your claim.

TIME OF PAYMENT OF CLAIMS

We will pay benefits within thirty (30) working days once We receive sufficient written Proof of Loss. If We do not pay benefits upon receipt of your claim, We shall have thirty (30) working days thereafter within which to mail to You a letter or notice which states the reasons We have for not paying the claim, either in whole or in part, and which also gives You a notice of any documents or other information needed to process the claim. When We have received sufficient written Proof of Loss from You, We shall then have thirty (30) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

PAYMENT OF CLAIMS

We will pay all benefits to You; benefits under this Policy are not subject to assignment. Upon receipt of Your death certificate, any benefits that have not been paid at the time of Your death may be paid to Your estate or Your designated Beneficiary. We have the right to pay up to $3,000 of those benefits to any Immediate Family Member who We believe is justly entitled to such payment. If We make a payment under this provision in good faith, We will be released from liability to the extent of the payment.

GENERAL PROVISIONS (Continued)

LEGAL ACTIONS

No legal action may be brought to recover benefits on this Policy before 60 days after We have received sufficient written Proof of Loss. No legal action may be brought against us more than two (2) years from the date written Proof of Loss was required to be provided.

AGE AND GENDER

If an Insured Person's Age or Gender is not correct as shown in this Policy, all benefits payable under this Policy will be such as the premium paid would have purchased at the correct Age or Gender. If the correct age is such that we would have obtained additional underwriting requirements or would not have issued this Policy, We will only be liable for a refund of any premiums paid for the period for which there was no coverage.

CONTESTABLE PERIOD

After two (2) years from the Effective Date (or the Reinstatement Date, if the Policy has been reinstated), no misstatements, except Fraudulent Misstatements, made by You in the application (or reinstatement application) shall be used to void this Policy or to deny a claim with a Date of Diagnosis after the expiration of such two (2) year contestable period. If We do not receive sufficient documentation from You to properly investigate Your claim that is within this 2 year contestable period, We retain the right to void the Policy and refund all premiums We have received. We will provide You with written notice fifteen (15) days before the Policy is voided. The Date of Diagnosis determines whether or not a claim is within the Contestable Period, NOT when the claim is received by Us. Misstatements, including Fraudulent Misstatements, made by You on the Application (or reinstatement application) may be used by Us to void this Policy or to deny a claim with a Date of Diagnosis within two (2) years after the Effective Date or within two (2) years after the Reinstatement of this Policy.

EFFECTIVE DATE

This Policy's Effective Date is the date shown on the Policy Schedule. This Policy will take effect at 12:01 AM in the time zone of Your last known address, on our Home Office records on the Effective Date. This Policy will terminate at 11:59 PM in the time zone of Your last known address, on our Home Office records on the date of termination. If this Policy lapses and is reinstated, the Effective Date is as described in the Reinstatement Provision.

TERMINATION

This Policy will terminate on the earliest of:

(a) the date on which this Policy lapses or terminates; or

(b) the date that the Critical Illness Benefit Maximum is paid; or

(c) any premium due date requested by You in writing to terminate this Policy; or

(d) the end of the Grace Period following the due date for which a premium was not paid; or

(e) the death of the Primary Insured; or

(f) The Primary Insured's age 90.

GENERAL PROVISIONS (Continued)

OWNER

The Insured is the Owner of this Policy unless later changed.

As Owner, You may exercise all rights in this Policy while the Insured Person is living. If You are without legal capacity, We will allow Your rights to be exercised by:

(a) a legally appointed Guardian responsible for Your property; or

(b) a person who We determine is responsible for Your welfare and support.

To exercise Your rights, You must follow the procedures stated in this Policy. All elections, designations, changes and requests must be made in writing and in a form acceptable to Us.

If You change Your beneficiary, address, or request any other action by Us, You should do so on the form prepared for each purpose. You may obtain such forms from Our Home Office at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, AL 35902.

BENEFICIARY

The beneficiary designated by You in the application or later changed on Our records will receive any benefits unpaid at Your death. Each beneficiary is classified as a Primary or Contingent Beneficiary. All surviving beneficiaries of the same class will share equally in any payments to that class, unless otherwise designated by You.

If no stated beneficiary is living at the time of Your Death, We will pay:

(a) the executor or administrator of Your estate; or

(b) Your spouse, child, or parent who We determine is entitled to payment

CHANGE OF OWNER OR BENEFICIARY

While the Insured Person is living, You may change:

(a) the Owner; or

(b) a Beneficiary designation, if it is not restricted by a previous designation.

We require that any change be endorsed by an authorized Officer of Our Company. Any change will be effective the date of Our endorsement. No agent or other representative has authority to endorse this Policy.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy that, on the coverage effective date, conflicts with any laws of the state where You lived when this Policy was issued, is amended to conform with the law.

LICOA
Life Insurance Company of Alabama
HOME OFFICE • GADSDEN, ALABAMA 35902

Protecting your financial security

CANCER BENEFIT POLICY

This is a Limited Benefit Policy

LIFE INSURANCE COMPANY OF ALABAMA agrees to pay the benefits according to the provisions of this Policy. All benefits are subject to its provisions, exclusions and limitations. This Policy is a legal contract between You and Us.

Signed for the Company at Gadsden, Alabama.

Secretary President

CONSIDERATION

This Policy is issued to You in consideration of Your application and the receipt of the first premium. This Policy is a legal contract between You and Us. Your Policy is effective at 12:01 a.m. on the Effective Date in the time zone of Your home address as indicated on the Policy Schedule page.

NOTICE OF RIGHT TO EXAMINE POLICY

You should read this entire contract carefully and refer to the DEFINITIONS section to understand the meaning of defined words. The application and any amendments or riders are a part of this contract. You must review and give special attention to make sure all of the information in the application and amendments are accurate and complete. You must notify Us of any information that is inaccurate, incomplete or omitted within thirty (30) days after delivery of this Policy. You may return this Policy within thirty (30) days after the delivery if You are not satisfied with it for any reason to: Life Insurance Company of Alabama, PO Box 349, Gadsden, AL 35902. The return of this Policy will void it from the Effective Date and any premium We receive will be refunded.

GUARANTEED RENEWABLE TO AGE 90

SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS BY CLASS

You may continue the coverage provided by this Policy by paying all premiums when due, until the Policy anniversary on or following the Expiry Date, subject to the Policy's Termination provision. We reserve the right to change the premium rates for this Policy. Any change in premium will be made on a premium class basis. No change in premium will become effective until 40 days after a notification is sent to Your last known address, on Our Home Office Records.

THIS IS A SPECIFIED DISEASE POLICY, WHICH ONLY PROVIDES BENEFITS FOR THE DIAGNOSIS OF ILLNESSES SPECIFIED AND DEFINED IN THIS POLICY. IT DOES NOT PAY BENEFITS FOR LOSS FROM ANY OTHER CAUSE. THIS POLICY DOES NOT CONTAIN DEATH BENEFITS. PLEASE READ THE CONTRACT CAREFULLY – IT CONTAINS WAITING PERIODS EXCLUSIONS AND LIMITATIONS.

TABLE OF CONTENTS

POLICY SCHEDULE PAGE **[policy no]**

FORM NO.	DESCRIPTION	UNITS	PLAN	PREMIUM
[HC88]	[CRITICAL ILLNESS]	[XXX.XXX]	[HC88]	[$XXX.XX]

TOTAL ANNUAL PREMIUM **[$XXX.XX]**

RENEWAL PREMIUMS

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY
[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]

***THE FOLLOWING BENEFITS ARE PAID FOR COVERAGE PROVIDED BY*:**

1. **[CRITICAL ILLNESS BENEFITS** **BENEFIT MAXIMUM (Amounts Based On XXX.XXX Units)**

   Cancer
   - **Invasive Cancer** **$ XXX**
   - **Non-Invasive Cancer** **$ XXX**

   [Legal Spouse **50% of the primary insured amount]**
   [Dependent Children **25%, per dependent child, of the primary insured amount]**

   The Benefit Maximum is Subject to a reduction of fifty percent (50%) on the Covered Person's attained age 70.

2. **[Optional Rider[(s)]]**

POLICY NUMBER: **[xxxxxxxxxx]**

INSURED: **[John Doe]** **[123 WALKING WAY]** **[ANYTOWN, AL, 12345]**

EFFECTIVE DATE: **[MM/DD/YYYY]**

ISSUE AGE: [XX] SEX:[MALE]
SMOKING STATUS: [NON-SMOKER]
POLICY WAITING PERIOD: [30 days for all Benefits]

PREMIUM: [$XXX.XX]
PAYABLE EVERY: [MONTH]

DEFINITIONS

As used in, and for the purposes of this Policy, the terms listed below will have the meanings as defined. The plural use of a term will share the same meaning as the singular.

AGE means the attained age as of Your last birthday.

CANCER for the purposes of this Policy means a malignant tumor characterized by uncontrolled growth of malignant cells and invasion of normal tissue. It also includes the following blood conditions: lymphoma, leukemia and multiple myeloma, myelodysplastic syndrome/neoplasm, and myeloproliferative syndrome/neoplasm. It does not include, Premalignant or benign conditions.

CARCINOMA IN SITU means a malignant neoplasm limited to the epithelium and confined within the basement membrane or the site of origin without having invaded neighboring tissue.

CLINICAL DIAGNOSIS means a Diagnosis and identification of a Covered Event or Covered Condition based on observation and history, diagnostic and laboratory studies, and symptoms.

COVERED EVENT or COVERED CONDITION means Invasive Cancer or Non-Invasive Cancer as each is defined in this Policy, including any applicable limitations and exclusions.

CRITICAL ILLNESS means only the illnesses or procedures listed in the Policy Schedule under "Critical Illness Benefits"

CRITICAL ILLNESS BENEFIT MAXIMUM means the maximum total dollar amount payable under this Policy stated in the Policy Schedule. The Critical Illness Benefit Maximum is reduced by fifty percent (50%) on Your attained age of 70 years.

DATE OF DIAGNOSIS means the date the Covered Event or Covered Condition of a Critical Illness is first Diagnosed. It is NOT the date the Diagnosis is communicated to You.

DEPENDENT CHILD OR DEPENDENT CHILDREN means any unmarried child (natural, step or adopted) of Yours who:

1) is less than nineteen (19) years old and living with You; or
2) is less than twenty-four (24) years old and attending an accredited school as a full time student. Such child must be legally dependent upon You for principal support and maintenance; or
3) is or becomes incapable of self-support because of mental or physical handicap while covered under this Policy and prior to attaining limiting age for Dependent Child(ren) under (1) or (2) above. The child must be legally dependent upon You for support and maintenance. We must receive proof of incapacity within thirty-one (31) days after coverage would otherwise terminate. Coverage will then continue as long as Your insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age twenty-four (24); or
4) is not living with You, but You are legally required to support such child, and the child would otherwise qualify under (1), (2) or (3) above.

The term Dependent Child(ren) does NOT include grandchild(ren) unless required by law.

Proof of legal status may be required from time to time on covered Dependent Child(ren).

DEFINITIONS (Continued)

DIAGNOSED or **DIAGNOSIS** means a definitive identification of the Critical Illness made by a Physician (where applicable, specializing in a particular area of medicine) and supported by documentation of all appropriate and defined studies:

1. based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
2. meets any diagnostic requirements stated in this Policy for the particular Critical Illness being diagnosed; and
3. performed during the lifetime of the Insured and not post-mortem.

EFFECTIVE DATE means the date that this Policy becomes effective. The Effective Date is stated on the Policy schedule page.

FRAUDULENT MISREPRESENTATIONS means information on the application that is stated incorrectly for the purposes of obtaining this Policy.

IMMEDIATE FAMILY OR **IMMEDIATE FAMILY MEMBER** includes anyone related to You or Your Legal Spouse in the following manner: spouse; brothers or sisters (including stepbrothers, stepsisters, half-brothers and half-sisters);children (including stepchildren); parents (including stepparents); grandparents (including step grandparents);grandchildren (including step-grandchildren); aunts and uncles; nieces and nephews; and spouses, as applicable, of any of the above.

INCUR or INCURRED means an event, incident, or condition that:

1. occurs on or after the Effective Date of this Policy, and
2. occurs while this Policy is in force, and
3. is Diagnosed during the life of the insured and not post mortem, and
4. is not specifically excluded by any definitions or exclusions in this Policy.

INSURED means the person named in the Policy Schedule Page.

LEGAL SPOUSE means Your spouse as recognized by federal law. Once this Policy has been issued, any consideration of an addition of a spouse, whether by first marriage or remarriage, requires the submission of a completed application and is subject to Our approval. Spouse coverage terminates upon divorce of marriage. Proof of legal status may be required upon Our request from time to time on a covered spouse.

MANIFESTS or MANIFESTED means a condition or symptom that would cause an ordinary prudent person to seek medical advice, care, or treatment.

MONTH means a calendar month.

DEFINITIONS (Continued)

PHYSICIAN means a person who:

1. is a legally qualified medical practitioner in good standing and a Doctorate of the healing arts licensed in the United States or its territories; and
2. practices within the scope of his or her license and specialty in the United States or its territories; and
3. is not the Insured Person; or
4. is not the Insured Person's Immediate Family Member or business associate; or
5. does not customarily reside in the same household as the Insured Person.

A Physician does NOT mean an emergency medical technician, nurse, nurse practitioner, physician's assistant, coroner or other medical personnel that does not meet the above qualifications.

PREMALIGNANT means a lump, growth, polyp, or tumor that is noncancerous, noninvasive, and not characterized by uncontrolled and destructive growth, but which has the potential to progress to cancer (become invasive). Premalignant conditions and conditions with malignant potential, including but not limited to, hyperplasia, dysplasia, anaplasia, atypia, leukoplakia and hypertrophy, are NOT considered to be Cancer.

REINSTATEMENT DATE means the date coverage under this Policy and any attached Riders becomes effective following Reinstatement. This date will be the date of Our approval in writing of the reinstatement of any coverage.

WE, OUR, COMPANY or US means Life Insurance Company of Alabama

YOU or YOUR refers to the Insured named in the Policy Schedule.

CRITICAL ILLNESS BENEFITS

We will pay the Critical Illness Benefit amount stated in the Policy Schedule (subject to all applicable Policy provisions including), if a Critical Illness is both Incurred (or Manifests, as stated in the Policy), and is Diagnosed more than 30 days after the Effective Date. Payment of the Critical Illness Benefit Maximum terminates this Policy. The Critical Illness Benefit Maximum is reduced by the amount of all Critical Illness Benefit amounts paid. The total of all Critical Illness Benefit payments cannot exceed the Critical Illness Benefit Maximum as stated in the Policy Schedule. No Critical Illness Benefit is payable more than once.

On Your attained age 70, all Critical Illness Benefits and the Critical Illness Benefit Maximum, less any benefits previously paid, will be reduced by one-half (50%).

CRITICAL ILLNESS BENEFITS (Continued)

BENEFIT PAYMENT CONDITIONS

The payment of benefits for a Critical Illness stated in the Policy Schedule is subject to the following conditions:

(a) the Critical Illness Incurs and/or Manifests as stated in the Policy; and

(b) the Critical Illness is Diagnosed, Incurred and Manifested after the Policy Waiting Period following the Effective date of this Policy; and

(c) the benefit payment is not excluded by any general or specific exclusion or limitation; and

(d) the Critical Illness Diagnosis is made by a legally licensed Physician during the lifetime of the Insured and not post mortem. No benefits are payable for Critical Illness Diagnosis made after the death of the Insured.

(e) All required Proofs of Loss must be received by the Company.

INVASIVE CANCER

For the purposes of this Policy, Invasive Cancer means any Cancer with the exception of the following Cancers that are excluded:

- Chronic lymphocytic leukemia that has not progressed to at least Rai stage I;
- All tumors or conditions that are histologically described as nonmalignant, benign, Premalignant, noninvasive, dysplasia (all grades) or Carcinoma In Situ.
- All skin cancers, unless there is a metastasis, or the tumor is a malignant melanoma of greater than 1.0 mm maximum thickness (regardless of Clark level or ulceration) as determined by histological examination using the Breslow method:
- Prostate cancer, unless histologically classified as Gleason score 7 or greater, or TNM classification T1bN0M0 or greater;
- Papillary carcinoma of the thyroid (1 cm or less in diameter) and confined to the thyroid; also known as microcarcinoma of the thyroid, and,
- Noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0M0 or lower.
- Evidence of cancer cells or cancer genetic material detected by molecular or biochemical probes only (including but not limited to proteomic or DNA/RNA-based techniques) with no lesion amenable to tissue diagnosis.

Cancer must be positively and clearly Diagnosed with histo-pathological confirmation. A Clinical Diagnosis will be accepted only if:

(a) a pathological Diagnosis cannot be made because it is medically inappropriate or life threatening; and

(b) there is medical evidence to support the Diagnosis; and

(c) a Physician is treating You for an Invasive Cancer; and

(d) the Diagnosis is made during Your lifetime and not post mortem.

INVASIVE CANCER BENEFIT

If Invasive Cancer both Manifests and is Diagnosed more than 30 days after the Effective Date, We will pay the Critical Illness Benefit stated in the Policy Schedule.

CRITICAL ILLNESS BENEFITS (Continued)

NON-INVASIVE CANCER

For the purposes of this Policy, Non-Invasive Cancer means and is limited to the following:

- Chronic lymphocytic leukemia that has not progressed beyond Rai stage 0.
- Carcinoma In Situ.
- Early stage melanoma, which for the purposes of this Policy, means a malignant melanoma of up to 1.0 mm maximum thickness (regardless of Clark level or ulceration) as determined by histological examination using the Breslow method;
- Early stage prostate cancer, which for the purposes of this Policy, means a localized cancer histologically classified as Gleason score 6 or less, and TNM classification T1aN0M0;
- Papillary microcarcinoma of the thyroid, which for the purposes of this Policy means a papillary carcinoma of the thyroid (1 cm or less in diameter) and confined to the thyroid;
- Noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0M0

The following are excluded from Non-Invasive Cancers:

- ALL Cancer of the skin including, but not limited to carcinoma and melanoma in situ of the skin
- All tumors or conditions that are histologically described as nonmalignant, benign or premalignant
- Evidence of cancer cells or cancer genetic material detected by molecular or biochemical probes only (including but not limited to proteomic or DNA/RNA based techniques) with no lesion amenable to tissue diagnosis.

Cancer must be positively and clearly Diagnosed with histopathological confirmation. A Clinical Diagnosis will be accepted only if:

(a) a pathological diagnosis cannot be made because it is medically inappropriate or life threatening; and

(b) there is medical evidence to support the diagnosis; and

(c) a Physician is treating You for a Non-Invasive Cancer; and

(d) the diagnosis is made during Your lifetime and not post mortem.

NON-INVASIVE CANCER BENEFIT

If Non-Invasive Cancer both Manifests and is Diagnosed more than 30 days after the Effective Date, We will pay the Non-Invasive Cancer Benefit stated in the Policy Schedule.

RIGHT TO EXAMINE FOR ALL CRITICAL ILLNESSES

We reserve the right to conduct a physical examination of the Insured and/or review any Critical Illness Diagnosed by a Physician of Our choosing. This Physician must:

(a) have specialty training and board certification in the field of Medicine specific to the Critical Illness being Diagnosed; and

(b) must follow all routinely accepted procedures and protocols in the Diagnosis of the Critical Illness.

EXCLUSIONS

We will NOT pay benefits for a loss while being, caused by, contributed to, or resulting from:

- Any act of war, declared or undeclared; or
- Active duty in the armed forces, National Guard, or any reserve unit; or
- Engaging in a felony, or participating in any riot or civil insurrection; or
- Engaging in an illegal activity; or participating in any riot or civil insurrection; or
- Any intentionally self-inflicted injury; suicide, or suicide attempt; or
- Under the influence of alcohol (including the operation of or passenger of a motor vehicle with a blood alcohol concentration in excess of the legal limit of the state in which the accident occurs) or a controlled substance unless legally prescribed and used in the manner consistent with that prescription; or
- Any benefits for conditions diagnosed outside of the United States unless the Diagnosis and Date of Diagnosis can be confirmed in the United States by a Physician; or
- Any illness, loss, or condition specifically excluded from the definition of any Critical Illness; or
- Any illness, loss, or condition not stated as a covered Critical Illness in this Policy; or
- Any Diagnosis made after the death of the Insured; or
- Any Critical Illness in which ALL of the criteria and Proof of Loss has not been received by the Company.

TERMINATION OF INSURANCE

Insurance coverage for You and Your Legal Spouse, if covered, will continue until the earliest of:

1) the Primary Insured's 90th birthday; or
2) the date any premium for this Policy is in default beyond the end of its Grace Period; or
3) the premium due date following Your written request for its termination.

In the event of Your death, coverage on any remaining Covered Persons will not terminate provided We receive a copy of Your death certificate and written notice to continue coverage within thirty (30) days of the date of Your death. If Your covered Legal Spouse or Dependent Child dies, You may request in writing to remove them from Your coverage.

If Your Legal Spouse is a Covered Person under this Policy and You and Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage, insurance coverage provided by this Policy on Your former Legal Spouse will automatically terminate on the 61st day following the date of the decree of the dissolution of marriage.

Insurance coverage on a Dependent Child will terminate automatically on the earliest of the following:

1) the date of the Dependent Child's marriage; or
2) the Dependent Child's nineteenth (19th) birthday, if not a full-time student at an accredited school; or
3) the Dependent Child's twenty-fourth (24th) birthday, if a full-time student at an accredited school and legally dependent on You for principal support and maintenance.

TERMINATION OF INSURANCE (Continued)

Insurance coverage will not terminate due to the Dependent Child's age if the child is both:

1) incapable of self-sustaining employment because of mental or physical handicap; and
2) currently dependent upon You for support and maintenance.

You ***must*** provide proof of the Dependent Child's mental or physical handicap and dependence upon You within thirty-one (31) days after coverage would otherwise terminate in order for coverage to continue under this Policy. Proof of continued incapacity and dependency ***must be*** furnished at Our request.

RIGHT OF CONVERSION

If You and Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage and Your Legal Spouse was a Covered Person under this Policy, then Your former Legal Spouse may apply and receive, without evidence of insurability, a Policy providing coverage NOT greater than the terminated coverage. To obtain the Policy, Your former Legal Spouse must make application to Us within sixty (60) days following the date of the decree of dissolution of marriage. The Primary Insured under this Policy at the time of the dissolution of marriage shall remain the Primary Insured under this Policy. Coverage terminates automatically for the former Legal Spouse on the 61st day following the date of the decree of the dissolution of marriage. Any covered Dependent Children may be covered under either Policy, but NOT both.

A Covered Person whose dependency terminates and who desires to continue coverage as a Primary Insured under a separate Policy may do so by notifying Us of the request in writing. The Dependent Child will have the right to continue coverage as the Primary Insured under a separate Policy providing coverage NOT greater than the previous coverage without a requirement for evidence of insurability and without interruption in coverage. To obtain the Policy, the Dependent Child must make application to Us within thirty-one (31) days after the termination of insurance under this Policy.

In order to be considered for coverage, any Legal Spouse or Dependent Child not listed on the initial application must make written application.

GENERAL PROVISIONS

ENTIRE CONTRACT

This Policy, with the attached application, any other pages, amendments, or endorsements attached, and any application for reinstatement, are the entire contract between You and Us. This contract is made in consideration of Your application and payment of premiums as required. We rely on all statements in the application and any application for reinstatement as being true to the best of Your knowledge. No change to this Policy will be valid unless it is in writing and signed by an authorized Officer of Life Insurance Company of Alabama. No agent or other representative has authority to change or waive any Policy provisions or extend the time for paying a premium.

GENERAL PROVISIONS (Continued)

PAYMENT OF PREMIUMS

The due date of the initial premium is the Policy Effective Date. The initial premium may be paid to Our Home Office or to one of the Company's authorized agents. Premiums after the initial premium must be paid to Our Home Office at P.O. Box 349, Gadsden, AL 35902. Upon receipt of Your death certificate, We will refund any premium paid for any monthly period following the date of death. The refund may be paid to Your estate or designated Beneficiary. Upon receipt of Your written notice to discontinue coverage, We will refund any premium paid for any monthly period following the date We received the written notice from You. The refund may be paid to You.

This Policy is not effective until the Effective Date regardless of the date of the first premium payment if any premium is paid prior to the Effective Date. Any premium received prior to issue of the Policy will be held pending issue of the Policy. If the Policy is not issued by Us, We will refund any premium being held. If We or any third party on Our behalf receive premiums by any method (including payroll deduction and bank draft) prior to the issue of this Policy, We assume NO liability for coverage until this Policy is issued by Us. Premiums must be paid in United States currency.

GRACE PERIOD

This Policy has a thirty (30) day Grace Period for paying premium. This means if a renewal premium is not paid by the date due, it may be paid during the following thirty (30) days. Any otherwise payable claim incurred during the Grace Period will NOT be paid until the past due premiums are paid provided the Policy has not lapsed or terminated.

LAPSE

Your Policy will lapse if any premium is not paid before the end of the Grace Period. The date of lapse will be the date that the unpaid premium was due. Your Policy will terminate upon lapse as of the last date to which premiums have been paid and provide NO further benefits.

REINSTATEMENT

If Your Policy lapses, You may request to reinstate it by:

1. submitting a written application for reinstatement within 60 days after the end of the Grace Period; and
2. providing any additional evidence of insurability as We may require; and
3. paying all required premium.

If We approve Your request for reinstatement, coverage will become effective as of the Reinstatement Date. Unless we have previously sent you a written notice of disapproval, the Policy will be reinstated on the 45th day after Our receipt of the required evidence of insurability or such earlier date that We approve such evidence.

We will not pay benefits for any Critical Illness that Incurs or Manifests, whichever is applicable as stated in this Policy, and/or is Diagnosed: before the end of 30 days after the Reinstatement Date.

Your rights and Our obligations under this Policy will be the same as before the Policy lapsed subject to the Reinstatement and Incontestable provisions.

If You do not request a reinstatement within 90 days from the date any unpaid premium was due, this Policy will remain terminated and no further benefits will be provided.

GENERAL PROVISIONS (Continued)

UNEARNED PREMIUM REFUND

If You die before the end of a Premium Period for which premium has been paid, We will refund the portion of premium, prorated monthly, that was applied to coverage for the time period beyond the end of the month in which death occurred.

NOTICE OF CLAIM

You must provide Us with written notice of claim within 60 days from the Date of Diagnosis, or as soon as reasonably possible, but in no event later than 180 days from the Date of Diagnosis. You must provide notice of claim at Our Home Office. Your notice of claim must include Your name, address, the Policy Number, and the Covered Condition or Covered Event for which you are claiming

CLAIM FORMS

When We receive Your notice of claim, we will provide You with the forms required to file a claim. If you do not receive the forms within 15 days, You will have met the time frame required for filing Your claim. if You have provided Us with a written statement of the nature and extent of Your loss and sufficient Proof of Loss within the time allowed for filing a Proof of Loss.

PROOF OF LOSS

You must provide Us with written Proof of Loss determined to be satisfactory to Us within 90 days from the Date of Diagnosis. If it is not reasonably possible for You to provide written Proof of Loss within the stated time, Your claim will not be affected if You provide the written Proof of Loss as soon as reasonably possible but in no event later than 12 months from the Date of Diagnosis.

Proof of Loss includes the claim form (or written statement as noted in Claim Forms section above), plus appropriate evidence needed to establish benefit eligibility, which may include, but not limited to, physician or hospital records, histo-pathological reports, operative reports and test reports.

You must provide to Us any authorizations to obtain medical records or other information needed to evaluate your claim.

TIME OF PAYMENT OF CLAIMS

We will pay benefits within thirty (30) working days once We receive sufficient written Proof of Loss. If We do not pay benefits upon receipt of your claim, We shall have thirty (30) working days thereafter within which to mail to You a letter or notice which states the reasons We have for not paying the claim, either in whole or in part, and which also gives You a notice of any documents or other information needed to process the claim. When We have received sufficient written Proof of Loss from You, We shall then have thirty (30) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

PAYMENT OF CLAIMS

We will pay all benefits to You; benefits under this Policy are not subject to assignment. Upon receipt of Your death certificate, any benefits that have not been paid at the time of Your death may be paid to Your estate or Your designated Beneficiary. We have the right to pay up to $3,000 of those benefits to any Immediate Family Member who We believe is justly entitled to such payment. If We make a payment under this provision in good faith, We will be released from liability to the extent of the payment.

GENERAL PROVISIONS (Continued)

LEGAL ACTIONS

No legal action may be brought to recover benefits on this Policy before 60 days after We have received sufficient written Proof of Loss. No legal action may be brought against us more than two (2) years from the date written Proof of Loss was required to be provided.

AGE AND GENDER

If an Insured Person's Age or Gender is not correct as shown in this Policy, all benefits payable under this Policy will be such as the premium paid would have purchased at the correct Age or Gender. If the correct age is such that we would have obtained additional underwriting requirements or would not have issued this Policy, We will only be liable for a refund of any premiums paid for the period for which there was no coverage.

CONTESTABLE PERIOD

After two (2) years from the Effective Date (or the Reinstatement Date, if the Policy has been reinstated), no misstatements, except Fraudulent Misstatements, made by You in the application (or reinstatement application) shall be used to void this Policy or to deny a claim with a Date of Diagnosis after the expiration of such two (2) year contestable period. If We do not receive sufficient documentation from You to properly investigate Your claim that is within this 2 year contestable period, We retain the right to void the Policy and refund all premiums We have received. We will provide You with Written Notice fifteen (15) days before the Policy is voided. The Date of Diagnosis determines whether or not a claim is within the Contestable Period, NOT when the claim is received by Us. Misstatements, including Fraudulent Misstatements, made by You on the Application (or reinstatement application) may be used by Us to void this Policy or to deny a claim with a Date of Diagnosis within two (2) years after the Effective Date or within two (2) years after the Reinstatement of this Policy.

EFFECTIVE DATE

This Policy's Effective Date is the date shown on the Policy Schedule. This Policy will take effect at 12:01 AM in the time zone of Your last known address, on our Home Office records on the Effective Date. This Policy will terminate at 11:59 PM in the time zone of Your last known address, on our Home Office records on the date of termination. If this Policy lapses and is reinstated, the Effective Date is as described in the Reinstatement Provision.

TERMINATION

This Policy will terminate on the earliest of:

(a) the date on which this Policy lapses or terminates; or

(b) the date that the Critical Illness Benefit Maximum is paid; or

(c) any premium due date requested by You in writing to terminate this Policy; or

(d) the end of the Grace Period following the due date for which a premium was not paid; or

(e) the death of the Primary Insured; or

(f) The Primary Insured's age 90.

GENERAL PROVISIONS (Continued)

OWNER

The Primary Insured is the Owner of this Policy unless later changed.

As Owner, You may exercise all rights in this Policy while the Insured Person is living. If You are without legal capacity, We will allow Your rights to be exercised by:

(a) a legally appointed Guardian responsible for Your property; or

(b) a person who We determine is responsible for Your welfare and support.

To exercise Your rights, You must follow the procedures stated in this Policy. All elections, designations, changes and requests must be made in writing and in a form acceptable to Us.

If You change Your beneficiary, address, or request any other action by Us, You should do so on the form prepared for each purpose. You may obtain such forms from Our Home Office at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, AL 35902.

BENEFICIARY

The beneficiary designated by You in the application or later changed on Our records will receive any benefits unpaid at Your death. Each beneficiary is classified as a Primary or Contingent Beneficiary. All surviving beneficiaries of the same class will share equally in any payments to that class, unless otherwise designated by You.

If no stated beneficiary is living at the time of Your Death, We will pay:

(a) the executor or administrator of Your estate; or

(b) Your spouse, child, or parent who We determine is entitled to payment

CHANGE OF OWNER OR BENEFICIARY

While the Insured Person is living, You may change:

(a) the Owner; or

(b) a Beneficiary designation, if it is not restricted by a previous designation.

We require that any change be endorsed by an authorized Officer of Our Company. Any change will be effective the date of Our endorsement. No agent or other representative has authority to endorse this Policy.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy that, on the coverage effective date, conflicts with any laws of the state where You lived when this Policy was issued, is amended to conform with the law.

APPLICATION FOR A&H INSURANCE - PART 1

Please Use Dark Ink Suitable for Photocopying.

Life Insurance Company of Alabama

P. O. Box 349 • Gadsden, Alabama 35902

Proposed Insured

1. NAME (Last, Suffix, First, M.I.) _____

BIRTHDATE ☐☐/☐☐/☐☐☐☐ STATE OF BIRTH ☐☐ SSN# ☐☐☐-☐☐-☐☐☐☐

If eligible for Medicare, deliver appropriate Medicare disclosure found on page 11

HEIGHT ☐'☐☐" WEIGHT ☐☐☐ MALE ☐ FEMALE ☐ _____ ☐☐ ISSUE STATE

Driver License #

ADDRESS _____

CITY _____ STATE ☐☐ ZIP ☐☐☐☐☐

EMAIL _____

PHONE ☐☐☐-☐☐☐-☐☐☐☐ PHONE #2 ☐☐☐-☐☐☐-☐☐☐☐

INSURED'S EMPLOYER _____ EMPLOYMENT DATE ☐☐/☐☐/☐☐☐☐

OCCUPATION _____

Describe and give exact duties

2. Has any person proposed for insurance used tobacco in any form within the last 24 months? Yes ☐ No ☐

3. Are all persons proposed for insurance citizens of U.S.A? Yes ☐ No ☐

Dependents

4. NAME	DATE OF BIRTH Mo.	Day	Yr.	STATE OF BIRTH	GENDER (M / F)	SOCIAL SECURITY NUMBER	HEIGHT (FT. IN.)	(LBS.) WEIGHT
PROPOSED LEGAL SPOUSE								
PROPOSED LEGAL CHILDREN								

If additional children, use a separate sheet of paper. Signed and dated by the Insured.

5. Do you have a current Medicaid eligibility card or other state sponsored insurance program? ☐ Yes ☐ No

DETAILS OF questions 2 - 20 answered "yes": Include question #, names and addresses of physicians and individuals to whom the history pertains in PART 8.

6. Has any person listed above and proposed for coverage ever tested positive for exposure to Human Immunodeficiency Virus (HIV) infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by Human Immunodeficiency Virus (HIV) infection or other sickness or condition derived from such infection?

☐ Yes ☐ No

HOME OFFICE USE

Payment Information

7. PAYMENT MODE *(Monthly Direct Bill Not Available)*

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

☐ Bank Draft ☐ Payroll Deduction ☐ Direct Bill

☐ Payment with app $_____ ☐ Draft first payment

Additional details_____

BILLING ADDRESS INFORMATION

☐ Proposed Insured's address ☐ Primary Owner's address

☐ Other Premium Payor's / Alternate billing address *(details below)*

Name _____

Street _____

City _____ *State*____ *ZIP*_____

☐ *Special arrangements* _____

If Bank Draft Payment is chosen, complete Authorization to Honor Checks on page 12

Existing Insurance

8. EXISTING INSURANCE

Will the policy(s) applied for replace any insurance in force on any proposed covered person? Yes ☐ No ☐

If YES, complete and submit attached replacement form (found on page 9) along with this application and list all in force insurance coverage(s) below.

Insured's Name	Company	Owner	Replacement	Amount	Year Issued
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		

Beneficiary Designation

9.	Name and Address	Relationship		%
Insured			Primary	
Insured			Contingent	
Spouse			Primary	
Spouse			Contingent	

If additional beneficiaries, use a separate sheet of paper. Signed and dated by the Insured.

APPLICATION FOR A&H INSURANCE - PART 3

CANCER INDEMNITY *☐ Advantage *☐ Choice
Health & Wellness Benefit ☐ $100 ☐ $50
Daily Room ☐ $300 ☐ $200 ☐$100
Rad. & Chemo. ☐ Option A ☐ Option B ☐ Option C
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
*Answer Question 11 $_____

First Occurrence Rider ☐ 2 Units ☐ 1 Unit / ☐ Level ☐ Building
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
$_____

Intensive Care Benefit: I75 ☐ *Rider ☐ ✤Stand Alone
☐ $300 ☐ $450 ☐ $600 ☐ Other _____ $_____
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
*Answer Question 12 ✤Answer Questions 12, 15 & 16

Specified Disease Benefit Rider* $_____
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
*Answer Question 13 Cancer Indemnity Total$_____

INPATIENT + OUTPATIENT HOSPITAL INDEMNITY PLAN*
☐ Payroll Only Plan (HI67) ☐ Individual Non-Payroll Plan (HI68)
☐ Individual ☐ One Parent ☐ Emp. & Spouse ☐ Two Parent
Daily Hospital Benefit $_____
OPTIONAL BENEFITS: Initial Conf. $_____
Surg. Benefit $_____ Emer. Acc. $_____
Outpat. Sickness $_____ Other $_____
Major Injury (Broken Bones) Units ☐ 1 ☐ 2 ☐ 3
*Record Height & Weight in Part 1 & Answer Questions 10(a) & 15 - 20
$_____

Intensive Care Benefit: I63*
☐ $300 ☐ $450 ☐ $600 ☐ Other _____ $_____
☐ Individual ☐ One Parent ☐ Two Parent
*Answer Question 12
Inpatient + Outpatient Plan Total $_____

VOLUNTARY GROUP DENTAL INSURANCE
☐ Plan I ☐ Plan II
☐ Children Orthodontic Care Rider [☐ Vision & Hearing Rider]
☐ Employee ☐ Employee/Children ☐ Family
*Answer Question 14 Dental Total $_____

CRITICAL ILLNESS
☐ Cancer Benefits** $_____ FACE AMOUNT
☐ Heart & Stroke Benefits* $_____ FACE AMOUNT
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
$_____
**Answer Questions 15 - 19
*Record Height & Weight in Part 1 Answer Questions 15 - 19

Intensive Care Benefit: I75 ☐ *Rider ☐ ✤Stand Alone
☐ $300 ☐ $450 ☐ $600 ☐ Other _____ $_____
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
*Answer Question 12 ✤Answer Questions 12, 15 & 16

Critical Illness Total $_____

ACCIDENT INCOME PROVIDER * ☐ $3000 ☐ $1500
SENIOR ACC. INCOME PROVIDER * ☐ $3000 ☐ $1500
☐ Individual ☐ One Parent ☐ Two Parent
*Answer Question 10(a) Accident Income Provider Total $_____

ACCIDENT DISABILITY PLAN * (90 Day Employment Required)
Pre-Packaged Plan ☐ 400 ☐ 600 ☐ 800 ☐ 1000 ☐ 1200
Applicant's Gross Monthly Income $_____
☐ 24 Hour Coverage ☐ Off-The-Job Only
☐ Emp ☐ Emp/Sp ☐ Emp/Ch ☐ Emp/Fam $_____
*Answer Question 10(a)

✦**BUILD A PLAN** Monthly Income $_____ FACE AMOUNT
Applicant's Gross Monthly Income $_____
☐ 24 Hour Coverage ☐ Off-The-Job Only
Benefit Period ☐ 6 months ☐ 1 Year
Accident Elimination Period ☐ 0 ☐ 7 Days
☐ Emp ☐ Emp/Sp ☐ Emp/Ch ☐ Emp/Fam $_____
*Answer Question 10(a)
✦Does not apply to Packaged Accident Disability Plans

*Sickness Disability Rider Mo. Inc. $_____ FACE AMOUNT
Benefit Period ☐ 6 month ☐ 1 year
Elimination ☐ 7 or ☐ 14 days ☐ 30 days $_____
*Record Height & Weight in Part 1 & Answer Questions 15 - 19

SICKNESS & ACCIDENT DISABILITY INCOME PLAN*
☐ Standard ☐ Preferred (90 Day Employment Required)
Monthly Disability Benefit $ _____ FACE AMOUNT
Applicant's Gross Monthly Income $ _____
Benefit Period ☐ 3 months ☐ 6 months ☐ 1 Year ☐ 2 Years
Accident Elimination Period ☐ 0 ☐ 7 ☐ 14 Days
Sickness Elimination Period ☐ 7 ☐ 14 ☐ 30 ☐ 60 ☐ 90 ☐ 180 Days
*Record Height & Weight in Part 1 & Answer Questions 10(a) and 15 - 20
$_____

Optional Benefits for Sickness &/or Accident Disability Plan:
Level of coverage (i.e. Emp, Emp/Sp, Emp/Ch, Emp/Fam) for optional benefits is determined by the level of coverage selected for base policy.

☐ ✦Initial Hospital Confinement Benefit $1000 $_____

✦Injury Treatment Benefit $_____
☐ $100 ☐ $150 ☐ $200 ☐ $250 ☐ $300

☐ ✦Health Screening Benefit $_____

✦AD&D Benefit $_____
☐ $10k ☐ $15k ☐ $20k ☐ $25k ☐ $30k

☐ Supplemental Injury Benefit $_____

☐ **Specific Loss Rider (Broken Bone)** $_____

Intensive Care Benefit* **I75** ☐ ✤Stand Alone $_____
☐ $300 ☐ $450 ☐ $600 ☐ Other _____
*Answer Question 12 ✤Answer Questions 12, 15 & 16
✦Does not apply to Pre-Packaged Accident Disability Plans
Sickness &/or Accident Disability Income Plan Total $_____

APPLICATION FOR A&H INSURANCE - PART 4

DETAILS OF questions 2 - 20 answered "yes": Include question #, names and addresses of physicians and individuals to whom the history pertains in PART 8.	PROPOSED INSURED		SPOUSE		CHILDREN	
	Yes	No	Yes	No	Yes	No
10a. Is any proposed insured currently in the hospital or receiving disability payments?	☐	☐	☐	☐	☐	☐
Answer 6, 10(a), (b) & (c) when offering a plan approved for E-Z Underwriting						
(b) Is proposed primary insured working at least 30 hours per week?	☐	☐				
(c) In the past 5 years has any proposed insured been treated by a licensed member of the medical profession for a heart attack, stroke, internal cancer, melanoma, disease or disorder of the lungs or hepatitis?	☐	☐				
11. CANCER ADVANTAGE & CHOICE	Yes	No	Yes	No	Yes	No
(a) Has any person proposed for coverage under this Policy within the last 24 months, had any elevated or rising PSA or CEA test or abnormal mammogram, pap smear, radiological exam (e.g. X-Ray, MRI, CAT Scan, sonogram, ultrasound, echo tests, etc.), biopsy or scope procedure (e.g. colonoscopy, endoscopy, etc.) or are awaiting further tests or test results?	☐	☐	☐	☐	☐	☐
(b) Has any person proposed for coverage under this Policy within the last five years, been diagnosed as having or been treated for any cancer, including skin cancer, Hodgkin's Disease and Leukemia, in any form?	☐	☐	☐	☐	☐	☐
(c) Has any person proposed for coverage under this Policy been diagnosed, as having or been treated for any cancer, including skin cancer, Hodgkin's Disease and Leukemia, in any form over five years ago?	☐	☐	☐	☐	☐	☐
If yes to question 11a or b any person(s) so designated will not be covered under the policy. If yes to question 11c, you are eligible for a policy that provides Option C Radiation & Chemotherapy Benefits and $100 per day Daily Room Benefit for the treatment of cancer. No additional amounts will be issued.						
12. INTENSIVE CARE: Has any proposed insured ever been diagnosed or treated for heart disease, heart attack, any heart condition, heart trouble or any abnormality of the heart?	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐
(a) Are you, your spouse, your fiancé, your companion or any other person to be covered by this policy/rider currently pregnant or taking fertility drugs?	☐	☐	☐	☐	☐	☐
If yes to question (a), we will issue an individual policy / rider on the adult male family member only.						
Answer Questions 12, 15, and 16 for Intensive Care Stand Alone Policy						
13. SPECIFIED DISEASE: Has any person proposed for coverage under this Policy ever had treatment or diagnosis of: • Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) • Botulism • Bubonic Plague • Cerebral Palsy • Cholera • Cystic Fibrosis • Diphtheria • Encephalitis (including encephalitis contracted from West Nile virus) • Huntington's Chorea • Lyme Disease • Malaria • Menningitis (Bacterial) • Multiple Sclerosis • Muscular Dystrophy • Myasthenia Gravis • Necrotizing Fasciitis • Osteomyelitis • Polio • Rabies • Reye's Syndrome • Rheumatic Fever • Rocky Mountain Spotted Fever • Scleroderma • Sickle Cell Anemia • Smallpox • Systemic Lupus • Tetanus • Toxic Shock Syndrome • Tuberculosis • Tularemia • Typhoid Fever • Variant Creutzfeldt-Jakob Disease (Mad Cow Disease) • Yellow Fever?	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐
14. DENTAL:	Yes	No	Yes	No	Yes	No
(a) Are all children listed legal dependents of the Proposed Insured or Spouse?	☐	☐				
(b) Is their permanent residence the residence of the Proposed Insured? *If "No", please explain in details section.*	☐	☐				
(c) Are any children listed a full-time student? *If "Yes", please explain in details section.*	☐	☐				
(d) Are all eligible family members listed above? *If "No", please explain in details section.*	☐	☐				
(e) Are you or any person to be insured covered by any other dental insurance policy or certificate? *If "Yes", please give name of the company, Policy Number, Covered Person(s) name in details section.*	☐	☐	☐	☐	☐	☐
(f) Will this policy replace existing coverage? *If yes, when will existing coverage terminate?*	☐	☐	☐	☐	☐	☐
(g) Is proposed primary insured working at least 30 hours per week?	☐	☐				

APPLICATION FOR A&H INSURANCE - PART 5

DETAILS OF questions 2 - 20 answered "yes": Include question #, names and addresses of physicians and individuals to whom the history pertains in PART 8.	PROPOSED INSURED		SPOUSE		CHILDREN	
15. HAS ANY PERSON proposed for insurance in Part 1:	Yes	No	Yes	No	Yes	No
(a) Used marijuana, narcotic, hallucinogenic or habit forming drugs not prescribed by a physician?	☐	☐	☐	☐	☐	☐
(b) Had any motor vehicle moving violations or accidents within the last two years?	☐	☐	☐	☐	☐	☐
(c) Been arrested for any reason other than moving traffic violations?	☐	☐	☐	☐	☐	☐
(d) Ever had an application for insurance or reinstatement of insurance declined, postponed, rated up or modified?	☐	☐	☐	☐	☐	☐
16. IN THE LAST 10 YEARS, HAS ANY PERSON proposed for insurance in Part 1 ever been treated by a licensed member of the medical profession for:	Yes	No	Yes	No	Yes	No
(a) Heart attack, chest pain, heart murmur, high blood pressure or any other disease of the heart, blood or blood vessels?	☐	☐	☐	☐	☐	☐
(b) Peptic ulcer, Ulcerative Colitis, Crohn's disease or any disease of the esophagus, stomach, intestines, pancreas or liver?	☐	☐	☐	☐	☐	☐
(c) Emphysema, bronchitis, asthma, Chronic Obstructive Pulmonary Disease (COPD) or any disease of the lungs or respiratory system?	☐	☐	☐	☐	☐	☐
(d) Hepatitis, diabetes, albumin, pus, blood or sugar in urine, venereal disease or any other disease of the kidneys, bladder, gland, reproductive organs or connective tissue disorder?	☐	☐	☐	☐	☐	☐
(e) Stroke, transient ischemic attack (TIA), severe headaches, fainting spells, epilepsy, paralysis, nervousness, mental disorder or any other disease of the brain, nervous system or been treated for a back or neck condition?	☐	☐	☐	☐	☐	☐
(f) Any disease or disorder of the eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐
(g) Alcohol or drug abuse?	☐	☐	☐	☐	☐	☐
(h) Any cancer or tumor including cancer of the bone marrow, blood, lymph nodes, carcinoma-in-situ, skin cancer or melanoma?	☐	☐	☐	☐	☐	☐
(i) Are you, your spouse, your fiancé, your companion or any other person to be covered by this policy/rider currently pregnant or taking fertility drugs?	☐	☐	☐	☐	☐	☐
(j) Any abnormality, deformity, disease, illness, injury or disorder not mentioned above?	☐	☐	☐	☐	☐	☐
17. OTHER THAN INDICATED ABOVE, has any person proposed for insurance in Part 1:	Yes	No	Yes	No	Yes	No
(a) Ever applied for or received a pension or disability benefit?	☐	☐	☐	☐	☐	☐
(b) Been hospitalized in the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(c) Consulted a physician during the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(d) Had a change of weight in the past year?	☐	☐	☐	☐	☐	☐
(e) Is proposed primary insured working at least 30 hours per week?	☐	☐	☐	☐	☐	☐
(f) Had an immediate family member (Father, Mother, Brothers or Sisters) with a history of diabetes, mental, nervous, heart or circulatory disorder, tuberculosis, cancer, high blood pressure, kidney disease or suicide? If so, include condition, relationship, age(s) if living, age(s) at death and cause of death.	☐	☐	☐	☐	☐	☐
18. IN THE LAST 24 MONTHS, has any person proposed for insurance in Part 1 been under observation or treatment of a physician or had or been advised to have any diagnostic test, procedure, screening or surgery or awaiting test results? If yes, please provide details including date(s), reason(s) and result(s).	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐
19. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? If yes please indicate if Retired or active: list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in PART 8.	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐
20. HAS ANY PERSON proposed for insurance in Part 1:	Yes	No	Yes	No	Yes	No
(a) Flown other than as a fare-paying passenger within the last two years or considering such flying in the next two (2) years? If yes, complete Aviation Questionnaire.	☐	☐	☐	☐	☐	☐
(b) Any past, present or expected (in the next two (2) years) activity in racing, skin or sky diving, bungee jumping, base jumping, parasailing, rock climbing, hang gliding or ultra-light flying? If yes, complete Hazardous Sports Questionnaire.	☐	☐	☐	☐	☐	☐

APPLICATION FOR A&H INSURANCE - PART 6

Please provide name of doctor, practitioner, or health care facility who can provide the most complete and up-to-date information concerning any health condition listed on Part 4 of this application for any Proposed Insured.

Physician Information

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION I hereby authorize the above person(s) or entity(s) listed in above and the Medical Information Bureau and any prescription drug or pharmacy organization(s) to provide **Life Insurance Company of Alabama**, or its reinsurers, or to **[Lab One/Exam One]** on the behalf of Life Insurance Company of Alabama, information, data, or records concerning advice, care, treatment or health history provided to the person(s) named above, including, but not limited to, notes, reports, test results, x-rays, documents related to any mental conditions, cost of medical services, prognosis, physician notes of patient interviews, patient notes, pharmacy records or other data and including the full and complete clinical records, hospital charts, examination records and medical history I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol program; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition; information relating to HIV testing, HIV status, or AIDS. I understand that such information may be subject to special protections pursuant to law and that by signing this authorization, I authorize the person(s) or entity(s) listed to disclose records containing such information. Please list any special instructions. I authorize Life Insurance Company of Alabama, or its reinsurers, to make a brief report of my personal health information to MIB. I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at: *Life Insurance Company of Alabama, Attn: Privacy Official, PO Box 349, Gadsden, AL 35902*. I understand that the revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when my insurance coverage ends (twenty-four (24) months from the date shown below in Kentucky and Oklahoma, thirty (30) months from the date shown below in Georgia and North Carolina), if not revoked before such date. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that this authorization is needed for the purpose of gathering information for making eligibility, underwriting and risk rating determinations.

BY MY SIGNATURE(s) below I do attest that the statements and answers in all parts of this application are complete and true and will be the basis for any insurance issued. If I am eligible for Medicare, I have received the Important Notice to Persons on Medicare.

Arkansas Only:
Is any person to be covered for specified disease is also covered by any Title XIX program Medicaid or similar coverage.
☐ Yes ☐ No

Signed at_____
City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Payor if other than Proposed Insured

AGREEMENT Terms used In this Agreement:
"You" and "Your" mean the Proposed Insured and the Applicant, if other than the Proposed Insured. "We", "us" and "our" mean the Life Insurance Company of Alabama. It is understood and agreed by you that:
(a) Any policy issued as a result of this application shall constitute a single and entire contract of insurance. Only the President, a Vice President, the Secretary or an Assistant Secretary of the Company may make a contract on its behalf. No waiver or modification of a contract provision or any of the Company's rights or requirements shall be binding upon the Company unless it is in writing signed by one of such officers. NEITHER THE AGENT WHOSE SIGNATURE APPEARS BELOW, NOR ANY OTHER AGENT OR BROKER, NOR ANY MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS, PASS UPON INSURABILITY, MAKE OR MODIFY CONTRACTS OR WAIVE ANY OF THE COMPANY'S RIGHTS OR REQUIREMENTS.
(b) To the best of your knowledge and belief all of the statements and answers on this application are true, complete and correctly stated. These statements and answers are offered to us as the basis for any policy issued on this application.
(c) Unless the policy becomes effective as specified in the Temporary Insurance Agreement attached to this application, we will incur no liability until (1) any policy applied for has been delivered to and accepted by you and (2) the first premium is paid. When you accept the policy, the state of health of the Proposed Insured and/or Applicant or any other factor affecting insurability must be the same as set forth in the application.
(d) Acceptance of the policy issued based on this application will be an acceptance of its terms and ratifications of any changes specified in the section marked "Home Office Endorsements". Any change in plan or amount of insurance, premium, classification or added benefits must be agreed to in writing.
(e) No Agent Broker or Medical Examiner can accept risks or waive any of our requirements, nor can the Agent, Broker or Medical Examiner make or alter contracts. Notice to or knowledge imputed to any Agent, Broker, Medical Examiner will not be notice to or knowledge of us unless it is set out in writing in this application.
(f) Any life insurance issued as a result of this application shall be owned by the applicant or by person(s) who receive ownership from the applicant.

Disclosures

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

Arkansas, Louisiana, Mississippi, North Carolina, South Carolina: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be subject to fines and confinement in prison.

Florida: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Georgia, Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to any insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial or insurance benefits.

As normal procedure, the Home Office Underwriting Department may contact you by telephone to verify pertinent information contained in your application. What is the best time to call?

Home/Office Phone:
Cell Phone:
Email address:

I represent that copies of all sales materials and required disclosures, including Medicare disclosure have been left with the Proposed Insured.

Writing Agent

_____
Print Name State License No. (Req. in FL)

X _____
Signature LICOA Agent's No.

_____
Agent LICOA Agent's No.

_____
Agent LICOA Agent's No.

_____
Agent LICOA Agent's No.

AGENT'S STATEMENT: To the best of your knowledge does this insurance replace any existing insurance? ☐ Yes ☐ No
If Yes, give name of company and policy number.

APPLICATION FOR A&H INSURANCE - PART 8

DETAILS OF questions 2 - 20 answered "yes": Include question #, names and addresses of physicians and individuals to who history pertains.

If additional details, use a separate sheet of paper. Signed and dated by the Insured.

APPLICATION FOR LIFE INSURANCE - PART 1

Please Use Dark Ink Suitable for Photocopying.

Life Insurance Company of Alabama

P. O. Box 349 • Gadsden, Alabama 35902

Proposed Insured

1. NAME (Last, Suffix, First, M.I.) _____

BIRTHDATE ___/___/___ STATE OF BIRTH ___ SSN# ___-___-___

If eligible for Medicare, deliver appropriate Medicare disclosure found on page 11

HEIGHT ___' ___" WEIGHT ___ MALE ☐ FEMALE ☐ _____ ISSUE STATE

Driver License #

ADDRESS _____

CITY _____ STATE ___ ZIP ___

EMAIL _____

PHONE ___-___-___ PHONE #2 ___-___-___

INSURED'S EMPLOYER _____ EMPLOYMENT DATE ___/___/___

OCCUPATION _____

Describe and give exact duties

1. Have you used tobacco in any form within the last 24 months? Yes ☐ No ☐ **1a. Citizen of U.S.A?** Yes ☐ No ☐

Coverage Type

	FACE AMOUNT	MODE PREMIUM
☐ QUICK ISSUE WHOLE LIFE ☐ E-Z Underwriting (Subject to Question 10 and Company Participation requirements)	$ ___,___	$ ___,___.___
☐ QUICK ISSUE LEVEL TERM ☐ 10 yr. ☐ 15 yr. ☐ 20 yr. ☐ 30 yr.	$ ___,___	$ ___,___.___
☐ ACCIDENTAL DEATH BENEFIT	$ ___,___	$ ___,___.___
☐ CHILDRENS TERM ___ UNITS 15 units maximum per family		$ ___,___.___
☐ WAIVER OF PREMIUM Waiver of Premium is not available with Critical Illness Benefits		$ ___,___.___
☐ CRITICAL ILLNESS CANCER BENEFITS	$ ___,___	$ ___,___.___
☐ CRITICAL ILLNESS HEART & STROKE BENEFITS	$ ___,___	$ ___,___.___
☐ AUTOMATIC PREMIUM LOAN Yes ☐ No ☐ Whole Life Only	TOTAL MODE PREMIUM	$ ___,___.___

Ownership

2. OWNER if other than PROPOSED INSURED

Name _____

Street _____

City _____ *State*____ *ZIP*_____

Relationship to Insured _____

Owner's SSN# or TAX ID# ___-___-___

Proposed Insured becomes owner: ☐ At age of majority ☐ At owner's death ☐ When specified in writing by owner

Children's Term

3. NAME Proposed Legal Children	DATE OF BIRTH Mo.	Day	Yr.	STATE OF BIRTH	GENDER (M / F)	SOCIAL SECURITY NUMBER	HEIGHT (FT. IN.)	(LBS.) WEIGHT

If additional children, use a separate sheet of paper. Signed and dated by the Insured.

APPLICATION FOR LIFE INSURANCE - PART 2

Spouse

1. NAME (Last, Suffix, First, M.I.) _____

BIRTHDATE ___/___/_____ STATE OF BIRTH ____ SSN# ___-___-_____

If eligible for Medicare, deliver appropriate Medicare disclosure found on page 11

HEIGHT ___' ___" WEIGHT _____ MALE ☐ FEMALE ☐ _____ ISSUE STATE ____

Driver License #

ADDRESS _____

CITY _____ STATE ____ ZIP _____

EMAIL _____

PHONE ___-___-_____ PHONE #2 ___-___-_____

INSURED'S EMPLOYER _____ EMPLOYMENT DATE ___/___/_____

OCCUPATION _____

Describe and give exact duties

1. Have you used tobacco in any form within the last 24 months? Yes ☐ No ☐ **1a. Citizen of U.S.A?** Yes ☐ No ☐

Coverage Type

	FACE AMOUNT	MODE PREMIUM
☐ QUICK ISSUE WHOLE LIFE ☐ E-Z Underwriting (Subject to Question 10 and Company Participation requirements)	$	$
☐ QUICK ISSUE LEVEL TERM ☐ 10 yr. ☐ 15 yr. ☐ 20 yr. ☐ 30 yr.	$	$
☐ ACCIDENTAL DEATH BENEFIT	$	$
☐ CHILDRENS TERM ____ UNITS 15 units maximum per family		$
☐ WAIVER OF PREMIUM Waiver of Premium is not available with Critical Illness Benefits		$
☐ CRITICAL ILLNESS CANCER BENEFITS	$	$
☐ CRITICAL ILLNESS HEART & STROKE BENEFITS	$	$
☐ AUTOMATIC PREMIUM LOAN Yes ☐ No ☐ Whole Life Only	TOTAL MODE PREMIUM	$

Ownership

2. OWNER if other than PROPOSED INSURED

Name _____

Street _____

City _____ *State*____ *ZIP*_____

Relationship to Insured _____

Owner's SSN# or TAX ID# ___-___-_____

Proposed Insured becomes owner: ☐ At age of majority ☐ At owner's death ☐ When specified in writing by owner

Children's Term

3. NAME Proposed Legal Children	DATE OF BIRTH Mo.	Day	Yr.	STATE OF BIRTH	GENDER (M / F)	SOCIAL SECURITY NUMBER	HEIGHT (FT. IN.)	(LBS.) WEIGHT

If additional children, use a separate sheet of paper. Signed and dated by the Insured.

Payment Info. Insured

If Bank Draft Payment is chosen, complete Authorization to Honor Checks

7. PAYMENT MODE *(Monthly Direct Bill Not Available)*

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

☐ Bank Draft ☐ Payroll Deduction ☐ Direct Bill

☐ Payment with app $_____ ☐ Draft first payment

Additional details_____

BILLING ADDRESS INFORMATION

☐ Proposed Insured's address ☐ Primary Owner's address

☐ Other Premium Payor's / Alternate billing address *(details below)*

Name _____

Street _____

City _____ *State*____ *ZIP*_____

☐ *Special arrangements* _____

Payment Info. Spouse

If Bank Draft Payment is chosen, complete Authorization to Honor Checks

7a. PAYMENT MODE *(Monthly Direct Bill Not Available)*

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

☐ Bank Draft ☐ Payroll Deduction ☐ Direct Bill

☐ Payment with app $_____ ☐ Draft first payment

Additional details_____

BILLING ADDRESS INFORMATION

☐ Spouse's address ☐ Primary Owner's address

☐ Other Premium Payor's / Alternate billing address *(details below)*

Name _____

Street _____

City _____ *State*____ *ZIP*_____

☐ *Special arrangements* _____

Existing Insurance

8. EXISTING or APPLIED FOR INSURANCE

Does any Proposed Insured have any existing life insurance or annuity contracts in force or applications pending? Yes ☐ No ☐

If YES, complete and submit attached replacement forms with this application and list all in force and pending life insurance coverage below.

Insured's Name	Company	Owner	Replacement	Life Amount	Accidental Death Benefit	Year Issued
			Yes ☐ No ☐			
			Yes ☐ No ☐			
			Yes ☐ No ☐			
			Yes ☐ No ☐			

Beneficiary Designation

9.	Name and Address	Relationship		%
Insured			Primary	
Insured			Contingent	
Spouse			Primary	
Spouse			Contingent	

If additional beneficiaries, use a separate sheet of paper. Signed and dated by the Insured.

MEDICAL QUESTIONS - PART 4

	PROPOSED INSURED		SPOUSE		CHILDREN TERM RIDER	
	Yes	No	Yes	No	Yes	No
10. IS ANY PERSON PROPOSED FOR INSURANCE currently in the hospital or receiving disability payments; or, in the past 5 years has any proposed insured been treated by a licensed member of the medical profession for a heart attack, stroke, internal cancer, melanoma, disease or disorder of the lungs, hepatitis, tested positive for exposure to Human Immunodeficiency Virus (HIV) infection or been diagnosed as having Aids Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the Human Immunodeficiency Virus (HIV) infection or other sickness or condition derived from such infection?	☐	☐	☐	☐	☐	☐
11. HAS ANY PERSON proposed for insurance in Part 1 and Part 2:						
(a) Used marijuana, narcotic, hallucinogenic or habit forming drugs not prescribed by a physician?	☐	☐	☐	☐	☐	☐
(b) Had any motor vehicle moving violations or accidents within the last two years?	☐	☐	☐	☐	☐	☐
(c) Been arrested for any reason other than moving traffic violations?	☐	☐	☐	☐	☐	☐
(d) Flown other than as a fare-paying passenger within the last two years or considering such flying in the next two (2) years? *(If yes, complete Aviation Questionnaire.)*	☐	☐	☐	☐	☐	☐
(e) Any past, present or expected (in the next two (2) years) activity in racing, skin or sky diving, bungee jumping, base jumping, parasailing, rock climbing, hang gliding or ultra-light flying? *(If yes, complete Hazardous Sports Questionnaire.)*	☐	☐	☐	☐	☐	☐
(f) Ever had an application for insurance or reinstatement of insurance declined, postponed, rated up or modified?	☐	☐	☐	☐	☐	☐
12. IN THE LAST 10 YEARS, HAS ANY PERSON proposed for insurance in Part 1 and Part 2 ever been treated by a licensed member of the medical profession for:						
(a) Heart attack, chest pain, heart murmur, high blood pressure or any other disease of the heart, blood, arteries or blood vessels?	☐	☐	☐	☐	☐	☐
(b) Peptic ulcer, Ulcerative Colitis, Crohn's disease or any disease of the esophagus, stomach, intestines, pancreas or liver?	☐	☐	☐	☐	☐	☐
(c) Emphysema, bronchitis, asthma, Chronic Obstructive Pulmonary Disease (COPD) or any disease of the lungs or respiratory system?	☐	☐	☐	☐	☐	☐
(d) Hepatitis, diabetes, albumin, pus, blood or sugar in urine, venereal disease or any other disease of the kidneys, bladder, gland, reproductive organs or connective tissue disorder?	☐	☐	☐	☐	☐	☐
(e) Stroke, transient ischemic attack (TIA), severe headaches, fainting spells, epilepsy, paralysis, nervousness, mental disorder or any other disease of the brain, nervous system or been treated for a back condition?	☐	☐	☐	☐	☐	☐
(f) Any disease or disorder of the eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐
(g) Tested positive for exposure to Human Immunodeficiency Virus (HIV) infection or been diagnosed as having Aids Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the Human Immunodeficiency Virus (HIV) infection or other sickness or condition derived from such infection?	☐	☐	☐	☐	☐	☐
(h) Alcohol or drug abuse?	☐	☐	☐	☐	☐	☐
(i) Any cancer or tumor including cancer of the bone marrow, blood, lymph nodes, carcinoma-in-situ, skin cancer or melanoma?	☐	☐	☐	☐	☐	☐
(j) Any abnormality, deformity, disease, illness, injury or disorder not mentioned above?	☐	☐	☐	☐	☐	☐
13. OTHER THAN INDICATED ABOVE, has any person proposed for insurance in Part 1 and Part 2:	Yes	No	Yes	No	Yes	No
(a) Ever applied for or received a pension or disability benefit?	☐	☐	☐	☐	☐	☐
(b) Been hospitalized in the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(c) Consulted a physician during the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(d) Had a change of weight in the past year?	☐	☐	☐	☐	☐	☐
(e) Had an immediate family member (Father, Mother, Brothers or Sisters) with a history of diabetes, mental, nervous, heart or circulatory disorder, tuberculosis, cancer, high blood pressure, kidney disease or suicide? In Details section below, include condition, relationship, age(s) if living, age(s) at death and cause of death.	☐	☐	☐	☐	☐	☐
14. IN THE LAST 24 MONTHS, has any person proposed for insurance in Part 1 & Part 2 been under observation or treatment of a physician or had or been advised to have any diagnostic test, procedure, screening, surgery or awaiting test results? If yes, please provide details including date(s), reason(s) and result(s).	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐
15. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please indicate if Retired or active: list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the space provided below for "Details".)*	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐

DETAILS OF questions 10 - 15 answered "yes": Include question #, names and addresses of physicians and individuals to whom the history pertains.

If additional details, use a separate sheet of paper. Signed and dated by the Insured.

AGREEMENT **Terms used In this Agreement:**
"You" and "Your" mean the Proposed Insured and the Applicant, if other than the Proposed Insured. "We", "us" and "our" mean the Life Insurance Company of Alabama. It is understood and agreed by you that:
(a) Any policy issued as a result of this application shall constitute a single and entire contract of insurance. Only the President, a Vice President, the Secretary or an Assistant Secretary of the Company may make a contract on its behalf. No waiver or modification of a contract provision or any of the Company's rights or requirements shall be binding upon the Company unless it is in writing signed by one of such officers. NEITHER THE AGENT WHOSE SIGNATURE APPEARS BELOW, NOR ANY OTHER AGENT OR BROKER, NOR ANY MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS, PASS UPON INSURABILITY, MAKE OR MODIFY CONTRACTS OR WAIVE ANY OF THE COMPANY'S RIGHTS OR REQUIREMENTS.
(b) To the best of your knowledge and belief all of the statements and answers on this application are true, complete and correctly stated. These statements and answers are offered to us as the basis for any policy issued on this application.
(c) Unless the policy becomes effective as specified in the Temporary Insurance Agreement attached to this application, we will incur no liability until (1) any policy applied for has been delivered to and accepted by you and (2) the first premium is paid. When you accept the policy, the state of health of the Proposed Insured and/or Applicant or any other factor affecting insurability must be the same as set forth in the application.
(d) Acceptance of the policy issued based on this application will be an acceptance of its terms and ratifications of any changes specified in the section marked "Home Office Endorsements". Any change in plan or amount of insurance, premium, classification or added benefits must be agreed to in writing.
(e) No Agent Broker or Medical Examiner can accept risks or waive any of our requirements, nor can the Agent, Broker or Medical Examiner make or alter contracts. Notice to or knowledge imputed to any Agent, Broker, Medical Examiner will not be notice to or knowledge of us unless it is set out in writing in this application.
(f) Any life insurance issued as a result of this application shall be owned by the applicant or by person(s) who receive ownership from the applicant.

Disclosures

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

Arkansas, Louisiana, Mississippi, North Carolina, South Carolina: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be subject to fines and confinement in prison.

Florida: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Georgia, Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to any insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial or insurance benefits.

As normal procedure, the Home Office Underwriting Department may contact you by telephone to verify pertinent information contained in your application. What is the best way to reach you?

Home/Office Phone:
Cell Phone:
Email address:

I represent that copies of all sales material have been left with the Proposed Insured.

Writing Agent

Print Name _____ State License No. (Req. in FL) _____

X _____
Signature _____ LICOA Agent's No. _____

Agent _____ LICOA Agent's No. _____

Agent _____ LICOA Agent's No. _____

Agent _____ LICOA Agent's No. _____

AGENT'S STATEMENT: To the best of your knowledge does this insurance replace any existing insurance? ☐ Yes ☐ No
If Yes, give name of company and policy number.

AGENT'S STATEMENT: Was the Temporary Life Insurance Agreement left with the owner? ☐ Yes ☐ No

APPLICATION FOR LIFE INSURANCE - PART 6

Please provide name of doctor, practitioner, or health care facility who can provide the most complete and up-to-date information concerning any health condition listed on Part 4 of this application for any Proposed Insured.

Physician Information

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ___ - ___ - ____

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ___ - ___ - ____

Patient Name _____ DOB_____

Physician/Hospital Names _____

Address _____

Conditions _____Dates of Service _____

Special Instructions: _____ Phone ___ - ___ - ____

AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION I hereby authorize the above person(s) or entity(s) listed in above and the Medical Information Bureau and any prescription drug or pharmacy organization(s) to provide **Life Insurance Company of Alabama**, or its reinsurers, or to **Lab One/Exam One** on the behalf of Life Insurance Company of Alabama, information, data, or records concerning advice, care, treatment or health history provided to the person(s) named above, including, but not limited to, notes, reports, test results, x-rays, documents related to any mental conditions, cost of medical services, prognosis, physician notes of patient interviews, patient notes, pharmacy records or other data and including the full and complete clinical records, hospital charts, examination records and medical history I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol program; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition; information relating to HIV testing, HIV status, or AIDS. I understand that such information may be subject to special protections pursuant to law and that by signing this authorization, I authorize the person(s) or entity(s) listed to disclose records containing such information. Please list any special instructions. I authorize Life Insurance Company of Alabama, or its reinsurers, to make a brief report of my personal health information to MIB. I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at: *Life Insurance Company of Alabama, Attn: Privacy Official, PO Box 349, Gadsden, AL 35902*. I understand that the revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when my insurance coverage ends (twenty-four (24) months from the date shown below in Kentucky and Oklahoma, thirty (30) months from the date shown below in Georgia and North Carolina), if not revoked before such date. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that this authorization is needed for the purpose of gathering information for making eligibility, underwriting and risk rating determinations.

BY THE SIGNATURE(s) below I (we) do attest that the statements and answers in all parts of this application are complete and true and will be the basis for any insurance issued.

HOME OFFICE ENDORSEMENTS:

Signed at_____
City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Owner or Applicant if other than Proposed Insured

X_____
Signature of Spouse

X_____
Signature of Owner or Applicant if other than Spouse

Temporary Life Insurance Agreement and Receipt

A copy of this Agreement is to be left with the owner if all questions are answered 'No' and pre-condition 2 is met. Second copy is sent with the Application.

Do not leave a copy of this Agreement or accept a payment if a question has a 'Yes" answer.

Instead, check "No" on the next page, page 8, and obtain the owner's initials under the acknowledgement section.

Definitions

For purposes of this Temporary Life Insurance Agreement ("Agreement"): "Application" means the Application for Individual Life Insurance from which this Agreement is to be and was physically detached and provided to the owner. "Agent" means the licensed individual who signed this Application as the Agent. "Proposed insured" means the person identified as the proposed life insured, and the person identified as the Spouse life insured, if any, in the Application. "Owner" is identified in the 'Information about the Owner' section of the Application.

Pre-Conditions to Temporary Coverage

Subject to the terms of this Agreement, Life of Alabama agrees to provide the temporary coverage set out in this Agreement if each of the following pre-conditions are met:

1. All questions in this Agreement are answered 'No' and the 'No' answers shown to the questions in this Agreement are truthful.
2. No later than the date of signing this Application, an amount equal to at least a monthly premium for the insurance applied for in the Application was given to the Agent or arrangements have been made for the insurance premium to be payroll deducted through the proposed insured's employer.

If either of the above pre-conditions are not met, no temporary coverage takes effect under this Agreement even if the Agreement was left with the owner.

Temporary Life Insurance Agreement Questions

	Proposed Insured	Spouse
1. Within the past 12 months, has there been either an investigation or treatment, or both, by a physician or medical practitioner for chest pain, heart-related illness, stroke or cancer?	☐ Yes ☐ No	☐ Yes ☐ No
2. Within the past 90 days, been admitted for more than 2 consecutive days to a hospital (other than for childbirth)?	☐ Yes ☐ No	☐ Yes ☐ No
3. Within the past 90 days, has a licensed medical professional recommended a medical test, investigation or surgery, or combination thereof, which was refused to be undertaken or has not yet been undertaken?	☐ Yes ☐ No	☐ Yes ☐ No

Amount given to Agent is $_____ ☐ No amount given to Agent.

Amount of Temporary Coverage

Subject to the terms of this Agreement, if all of the above pre-conditions are met and a proposed insured dies while this Agreement is in effect, Life of Alabama shall pay under this and all other Life of Alabama temporary life insurance agreement(s), to the beneficiary(ies), as shown in the Application, for that proposed insured, the lesser of:

1. The amount of insurance applied for in the Application on the life of that deceased proposed insured, including the amount payable for the death of that proposed insured under a rider applied for; or
2. $100,000.

Termination of Temporary Coverage

Subject to the terms of this Agreement, if temporary coverage takes effect under this Agreement, temporary coverage will terminate, and shall be of no further in force or effect, on the earliest of the following:

1. Sixty (60) days from the date shown in the Application as the date that the Application was signed by the owner. That date shall be the first day for purposes of calculating this sixty (60) day period.
2. The date an approved Life of Alabama policy on the life of a proposed insured takes effect as described in that policy, if a policy is issued in response to the Application.
3. The date Life of Alabama offers, as shown in Life of Alabama's records, the owner a Life of Alabama policy in response to, but not as applied for in, the Application.
4. The date a written or oral request to withdraw the Application is made by or on behalf of a proposed insured or the owner.
5. The date a written or oral request to terminate this Agreement is made by or on behalf of a proposed insured or the owner.
6. The date written notice is sent by Life of Alabama, as shown in Life of Alabama's records, to a proposed insured or the owner, terminating this Agreement.
7. The date written notice is sent by Life of Alabama, as shown in Life of Alabama's records, to the proposed insured or the owner, declining the Application.

Special Limitations

1. Fraud, material misrepresentation or non-disclosure in the Application will void this Agreement and limit Life of Alabama's liability to a refund of payment(s) made to Life of Alabama.
2. This Agreement shall be void if a check or draft given to the Agent is not honored when presented for payment.
3. If a proposed insured dies by suicide, whether sane or insane, Life of Alabama's liability under this Agreement is limited to a refund of the payment(s) made to Life of Alabama.
4. No temporary coverage will be provided under this Agreement to a proposed insured whose age is 66 or older on the date the Application is signed by the owner.

Payment to Life of Alabama

A check given to the Agent must be made payable to Life of Alabama. Do not make check payable to the Agent or leave the payee blank.

Entire Agreement

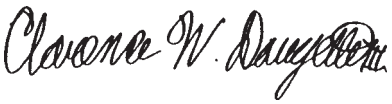
This Agreement contains the entire terms regarding temporary coverage. No one, including the Agent signing in the signature section of the Application, is authorized to waive, modify or change in writing, orally, or otherwise the terms of this Agreement or to promise or represent the terms of this Agreement other than as expressly written in this Agreement.

Governing Law

This Agreement shall be governed by and subject to the laws of the State in which this Agreement was delivered to the owner.

I, a proposed insured and/or the owner, by signing in the signature section of this Application, acknowledge and agree that I have reviewed, understand, and accept the terms of this Temporary Life Insurance Agreement, including the pre-conditions and special limitations to temporary coverage and the amount and termination of temporary coverage.

Countersigned



Clarence W. Daugette, III
President

Temporary Life Insurance Agreement Acknowledgement

Was this Temporary Life Insurance Agreement left with the owner? ☐Yes ☐No
If No, owner acknowledges that there is no temporary life insurance coverage in effect _____
(owner's initials)

X _____
Agent Signature LICOA Agent's No.

Signed at_____
City State

Date_____
Month Day Year

X_____
Signature of Proposed Insured

X_____
Signature of Owner or Applicant if other than proposed insured

X_____
Signature of Spouse

X_____
Signature of Owner or Applicant if other than spouse

Life Insurance Company of Alabama

302 Broad Street
Gadsden, Alabama 35901
800-226-2371

CANCER BENEFIT POLICY

Form Number HC882012

OUTLINE OF COVERAGE

THE POLICY PROVIDES LIMITED BENEFITS

THE POLICY IS A SPECIFIED DISEASE INDEMNITY POLICY WHICH ONLY PROVIDES BENEFITS FOR CANCER. IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS, CONDITION OR INCAPACITY.

THIS IS A LIMITED BENEFIT POLICY – PLEASE READ YOUR POLICY CAREFULLY - This outline of coverage provides a very brief description of some of the important features of the policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and the Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

CANCER INSURANCE COVERAGE – Policies of this category are designed to provide persons insured, restricted coverage paying ONLY when certain losses occur as a result of cancer. Coverage is not provided for basic hospital, basic medical-surgical, or major medical or comprehensive expenses.

BENEFITS

Qualifying For Benefits
We will pay the Critical Illness Benefit selected, if a Critical Illness is Incurred (or Manifests) and is Diagnosed more than 30 days after the Effective Date.

Critical Illness Benefit

1. The Critical Illness Benefit Maximum is reduced by the amount of all Critical Illness Benefit amounts paid.
2. The total of all Critical Illness Benefit payments cannot exceed the Critical Illness Benefit Maximum.
3. No Critical Illness Benefit is payable more than once.
4. Payment of the Critical Illness Benefit Maximum terminates the policy.
5. On Your attained age 70, all Critical Illness Benefits and the Critical Illness Benefit Maximum, less any benefits previously paid, will be reduced by one-half (50%).

Benefit Payment Conditions
The payment of benefits for a Critical Illness is subject to the following conditions:

1. The benefit payment is not excluded by any general or specific exclusion or limitation.
2. The Critical Illness Diagnosis is made by a legally licensed Physician during the lifetime of a Covered Person and not post mortem. No benefits are payable for Critical Illness Diagnosis made after the death of a Covered Person.

Critical Illness – Invasive and Non Invasive Cancer
In the policy, the term Critical Illness means Invasive and Non Invasive Cancer. Benefits are not provided for any other Critical Illness.

Invasive Cancer Benefit
We will pay the Critical Illness Benefit if Invasive Cancer both Manifests and is Diagnosed more than 30 days after the Effective Date of the policy.
Cancer must be positively and clearly Diagnosed with histo-pathological confirmation. A Clinical Diagnosis will be accepted only if:

1. a pathological Diagnosis cannot be made because it is medically inappropriate or life threatening; and
2. there is medical evidence to support the Diagnosis; and
3. a Physician is treating You for an Invasive Cancer; and
4. the Diagnosis is made during Your lifetime and not post mortem.

Invasive Cancers Which Are Excluded:
Invasive Cancer means any Cancer with the exception of the following Cancers:

- Chronic lymphocytic leukemia that has not progressed to at least Rai stage I;
- All tumors or conditions that are histologically described as nonmalignant, benign, Premalignant, noninvasive, dysplasia (all grades) or Carcinoma In Situ.
- All skin cancers, unless there is a metastasis, or the tumor is a malignant melanoma of greater than 1.0 mm maximum thickness (regardless of Clark level or ulceration) as determined by histological examination using the Breslow method:
- Prostate cancer, unless histologically classified as Gleason score 7 or greater, or TNM classification T1bN0M0 or greater;
- Papillary carcinoma of the thyroid (1 cm or less in diameter) and confined to the thyroid; also known as microcarcinoma of the thyroid, and,
- Noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0M0 or lower.
- Evidence of cancer cells or cancer genetic material detected by molecular or biochemical probes only (including but not limited to proteomic or DNA/RNA-based techniques) with no lesion amenable to tissue diagnosis.

Non Invasive Cancer Benefit
We will pay the Critical Illness Benefit if Invasive Cancer both Manifests and is Diagnosed more than 30 days after the Effective Date of the policy.

Cancer must be positively and clearly Diagnosed with histo-pathological confirmation. A Clinical Diagnosis will be accepted only if:

1. a pathological Diagnosis cannot be made because it is medically inappropriate or life threatening; and
2. there is medical evidence to support the Diagnosis; and
3. a Physician is treating You for an Invasive Cancer; and
4. the Diagnosis is made during Your lifetime and not post mortem.

Non-Invasive Cancer means and is limited to the following:

- Chronic lymphocytic leukemia that has not progressed beyond Rai stage 0.
- Carcinoma In Situ.
- Early stage melanoma, which for the purposes of the policy, means a malignant melanoma of up to 1.0 mm maximum thickness (regardless of Clark level or ulceration) as determined by histological examination using the Breslow method;
- Early stage prostate cancer, which for the purposes of the policy, means a localized cancer histologically classified as Gleason score 6 or less, and TNM classification T1aN0M0;
- Papillary microcarcinoma of the thyroid, which for the purposes of the policy means a papillary carcinoma of the thyroid (1 cm or less in diameter) and confined to the thyroid;
- Noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0M0

Non-Invasive Cancers Which Are Excluded:

- ALL Cancer of the skin including, but not limited to carcinoma and melanoma in situ of the skin
- All tumors or conditions that are histologically described as nonmalignant, benign or premalignant
- Evidence of cancer cells or cancer genetic material detected by molecular or biochemical probes only (including but not limited to proteomic or DNA/RNA based techniques) with no lesion amenable to tissue diagnosis.

Important Definitions

Cancer means a malignant tumor characterized by uncontrolled growth of malignant cells and invasion of normal tissue. It also includes the following blood conditions: lymphoma, leukemia and multiple myeloma, myelodysplastic syndrome/neoplasm, and myeloproliferative syndrome/neoplasm. It does not include, Premalignant or benign conditions.

Carcinoma In Situ means a malignant neoplasm limited to the epithelium and confined within the basement membrane or the site of origin without having invaded neighboring tissue.

Critical Illness Benefit Maximum means the maximum total dollar amount payable under the policy. The Critical Illness Benefit Maximum is reduced by fifty percent (50%) on Your attained age of 70 years.

Diagnosed or Diagnosis means a definitive identification of the Critical Illness made by a Physician (where applicable, specializing in a particular area of medicine) and supported by documentation of all appropriate and defined studies:

1. based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
2. meets any diagnostic requirements stated in the policy for the particular Critical Illness being diagnosed; and
3. performed during the lifetime of the Insured and not post-mortem.

Effective Date means the date that the policy becomes effective.

Important Definitions (Continued)

Incur or Incurred means an event, incident, or condition that:

1. occurs on or after the Effective Date of the policy, and
2. occurs while the policy is in force, and
3. is Diagnosed during the life of the insured and not post mortem, and
4. is not specifically excluded by any definitions or exclusions in the policy.

Manifests or Manifested means a condition or symptom that would cause an ordinary prudent person to seek medical advice, care, or treatment.

Physician means a person who:

1. is a legally qualified medical practitioner in good standing and a Doctorate of the healing arts licensed in the United States or its territories; and
2. practices within the scope of his or her license and specialty in the United States or its territories; and
3. is not the insured person; or
4. is not the insured person's immediate family member or business associate; or
5. does not customarily reside in the same household as the insured person.

A Physician does NOT mean an emergency medical technician, nurse, nurse practitioner, physician's assistant, coroner or other medical personnel that does not meet the above qualifications.

Premalignant means a lump, growth, polyp, or tumor that is noncancerous, noninvasive, and not characterized by uncontrolled and destructive growth, but which has the potential to progress to cancer (become invasive). Premalignant conditions and conditions with malignant potential, including but not limited to, hyperplasia, dysplasia, anaplasia, atypia, leukoplakia and hypertrophy, are NOT considered to be Cancer.

Exclusions and Limitations

We will not pay benefits for a loss while being, caused by, contributed to, or resulting from:

- ❑ Any act of war, declared or undeclared, or
- ❑ Active duty in the armed forces, National Guard, or any reserve unit, or
- ❑ Engaging in a felony, or participating in any riot or civil insurrection; or
- ❑ Engaging in an illegal activity; or participating in any riot or civil insurrection; or
- ❑ Any intentionally self-inflicted injury; suicide, or suicide attempt, or
- ❑ Under the influence of alcohol (including the operation of or passenger of a motor vehicle with a blood alcohol concentration in excess of the legal limit of the state in which the accident occurs) or a controlled substance unless legally prescribed and used in the manner consistent with that prescription; or
- ❑ Any benefits for conditions diagnosed outside of the United States unless the Diagnosis and Date of Diagnosis can be confirmed in the United States by a Physician; or
- ❑ Any illness, loss, or condition specifically excluded from the definition of any Critical Illness
- ❑ Any illness, loss, or condition not stated as a covered Critical Illness in the policy.
- ❑ Any Diagnosis made after the death of the insured.
- ❑ Any Critical Illness in which ALL of the criteria and Proof of Loss has not been received by the Company.

Renewability

You may continue the coverage provided by the policy by paying all premiums when due, until the policy anniversary on or following the expiry date, subject to the policy's termination provision.

Premium.

We reserve the right to change the premium rates for the policy. Any change in premium will be made on a premium class basis. No change in premium will become effective until 40 days after a notification is sent to your last known address, on Our Home Office Records.

Benefit Amount Selections		**Premium**
Cancer Base Plan		**$** _____
Critical Illness Maximum Benefit Amount		
Invasive Cancer Benefit Amount	_____	
Non Invasive Cancer Benefit Amount	_____	
Optional Riders		
☐ **Wellness Rider**		**$** _____
	Total Premium	**$** _____